RENEWAL APPLICATION

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

The Tennessee Legislature established effective January 15, 2011, the Department of Intellectual and Developmental Disabilities (DIDD) as a stand-alone department. The department is no longer a division in the Department of Finance and Administration, but has a Commissioner who is a member of the Governor's cabinet. An important aspect of the departmental restructuring was creation of three critical leadership positions: Deputy Commissioners of Policy and Innovation, Program Operations, and Office of Health Services, respectively.

The department's scope of responsibility was expanded to include individuals with developmental disabilities as well as licensure of individuals and agencies that provide services to individuals with intellectual and or developmental disabilities.

References to the Division of Intellectual Disability Services (DIDS) will be replaced with Department of Intellectual and Developmental Disabilities (DIDD).

Based on changes made in Rosa's Law in 2010, Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR) will reflect nationwide changes and be referred to as Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

Inaccurate references to independent advocacy available through a sub-contract managed by the Financial Management Services/Supports Brokerage entity were deleted. Independent advocacy continues to be available to persons supported by the Financial Management Services/Supports Brokerage entity.

We expand upon the circumstances under which a person who continues to be eligible for the Self Determination Waiver program may be involuntarily required to terminate self-direction as the method of service provision and receive services through the standard method of service delivery.

The definition of Day Services was revised to clarify expectations for providers and the description was reorganized for clarity. In addition, the definitions of Day, Personal Assistance, and Respite Services were revised to clarify that services shall not be provided during the same time period that the person is receiving services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof or as a substitute for education services which are available pursuant to IDEA, but which the person or his representative has elected to forego.

We propose to create a new Day service called In-home Day Services. The value of this service is that people who are unable to participate in community-based, facility-based, or supportive employment, can be supported at their place of residence.

We propose to create a new service called Semi-independent Living. This service is designed for people who require intermittent support beyond what is available through personal assistance services in order to remain in the community yet do not require direct support staff to live on-site.

We propose that reimbursement to family members providing waiver services shall be limited to forty hours per week per family member, for self-directed services as well as those delivered by

contracted provider agencies. In addition, the person's Circle of Support is responsible for determining if the use of family members to deliver paid care is the best choice for the person supported and shall ensure that paid services do not supplant natural supports that would otherwise be provided at no cost to the Medicaid program.

We propose to change the state's quality management system by adding, modifying, or deleting specific performance measures. The department collaborated with TennCare and the CMS HCBS quality consultant from Thompson Reuters (currently known as Truven Health) in creating this proposal.

We clarify that case managers conduct quarterly (or more frequently when needed) face-to-face monitoring visits with the person supported. The frequency of such visits shall be specified in the plan of care/ISP.

Furthermore, we propose to add as a new provider type for certain services the Department of Intellectual and Developmental Disabilities acting as an Organized Health Care Delivery System. The services are Specialized Medical Equipment, Supplies, and Assistive Technology, Behavior Services, Dental Services, Nutrition Services, Occupational Therapy, Physical Therapy, and Speech and Language and Hearing Services. This is largely because of capacity created at our Developmental Centers (State ICFs/IID) where specialized expertise in these areas was developed in order to serve residents. As the facilities are being downsized or closed, the State wishes to preserve that expertise and continue to make it available as people transition into community settings. The Quality Improvement Strategy has also been modified to reflect that the Medicaid Agency will perform the Qualified Provider review and would conduct the post-payment review processes for these State entities.

Finally, the description of billing and payment processing was updated to reflect that the single state Medicaid agency is responsible for direct payment to providers.

3.A. Components of the Approved Waiver Affected by the Amendment

Component of the Approved Waiver Subsection(s)	
Waiver Application	X
Appendix A – Waiver Administration and Operation	X
Appendix B – Participant Access and Eligibility	X
Appendix C – Participant Services	X
Appendix D – Participant Centered Service Planning and Delivery	X
Appendix E – Participant Direction of Services	X
Appendix F – Participant Rights	
Appendix G – Participant Safeguards	X
Appendix H – Quality Improvement Strategy	X
Appendix I – Financial Accountability	X
Appendix J – Cost-Neutrality Demonstration	X

APPLICATION

2. Brief Waiver Description:

The Self-Determination Waiver Program serves Tennessee citizens with ~~mental retardation~~ an intellectual disability who have moderate service needs that can be met with a cost-effective array of home and community services that complement other supports available to them in their homes and the community. The Self-Determination Waiver Program affords participants the opportunity to lead the person-centered planning process and directly manage selected services, including the recruitment and management of service providers. Participants and families (as appropriate) electing self-direction are empowered and have the responsibility for managing, in accordance with waiver service definitions and limitations, a self-determination budget affording flexibility in service design and delivery. During the development of the Individual Support Plan (ISP)/plan of care, individuals and families receive an orientation to self-direction, including information concerning added responsibilities and benefits of self-direction. When self-direction is selected, the ISP details services that will be participant-managed. Participants and families who prefer may elect to receive some or all of their services through the standard service delivery method through which an enrolled service provider chosen by the individual hires and manages the staff, delivers the service in accordance with the ISP and is paid directly by the state.

The target population for the Self-Determination Waiver Program consists of children with developmental delays and children and adults with ~~mental retardation~~ an intellectual disability who meet ICF/~~MR~~IID level of care criteria and who qualify for enrollment into the waiver program. The Self-Determination Waiver Program serves persons who have an established non-institutional place of residence where they live with their family, a non-related caregiver or in their own home and whose needs can be met effectively by the combination of waiver services through this program and natural and other supports available to them. The Self-Determination Waiver does not include residential services such as supported living.

To enroll in this program, the participant must:
• Live in Tennessee;
• Be financially eligible for Medicaid;
• Meet Medicaid criteria for payment of ICF/~~MR~~IID care and for waiver services;
• Have adequate caregiver support (see *1 below) to assure the participant's health and safety; and
• Not need staff-supported residential services.

The following waiver services are available based on assessed participant need:
Adult Dental Services
Personal Assistance
Personal Emergency Response Systems
Physical Therapy Services
Behavioral Respite Services
Behavior Services
Day Services
Respite
Environmental Accessibility Modifications
Specialized Medical Equipment & Supplies & Assistive Technology
Individual Transportation Services
Nutrition Services
Speech, Language, & Hearing Services
Occupational Therapy Services

Nursing Services
Orientation and Mobility Services for Impaired Vision
Semi-Independent Living Services
~~Vehicle Accessibility Modifications~~

*1. Caregiver Support
The case manager is responsible for completing an enrollment assessment which includes the identification of caregivers available to provide needed support to the participant, as well as gathering information about the caregivers (e.g., their employment status, work schedule, and health status). Although not required to conduct specific activities, it is important for the case manager to assess the availability of caregivers and the supports they provide in order to ensure that paid services do not supplant natural supports and to ensure that the person's ~~service recipient's~~ needs will be appropriately met through a combination of waiver-funded services and uncompensated care. The case manager is responsible for monitoring the adequacy of all supports and services, including caregiver support, through quarterly face-to-face monitoring visits and review of the implementation of the plan of care. While conducting the annual risk assessment, if the case manager determines there has been a change in the participant's circumstances or needs, including caregiver changes or adequacy of caregiver support, and the participant's needs are no longer being met, the case manager will assess whether the participant's needs can be met through additional waiver services or whether their needs could be better met by choosing to transfer to another Home and Community Based Services waiver.

3. Components of the Waiver:
No change

4. Waiver(s) requested
No change

5. Assurances
No change

6. Additional Requirements:

I. Public Input:

One way in which the state secures public input in to the development of the waiver is through the statewide and regional planning and policy councils. The councils are composed of consumers, family members, waiver service providers, guardians and advocates, and staff of the Bureau of TennCare and the ~~Division of Intellectual Disabilities Services~~ Department of Intellectual and Developmental Disabilities (DIDD). Regular meetings provide stakeholders the opportunity to discuss a variety of issues involving the operation of the waiver, policy changes, and waiver development. This allows all stakeholders to be represented and feel a sense of ownership and pride in the Self-Determination Waiver Program.

Information obtained from such stakeholder participation guides the development of the waiver and the services and service methods employed.

7.B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver:

~~JoAnna Damons~~
~~Assistant Commissioner of Policy and Planning~~
~~Division of Intellectual Disabilities Services~~

~~500 Deaderick St.~~
~~Nashville, TN 37243~~
~~Phone: 615-253-XXXX~~
~~Fax: 615-532-9940~~

Scott Modell, Ph. D.
Deputy Commissioner of Policy and Innovation
Department of Intellectual and Developmental Disabilities
Division of Intellectual Disabilities Services
500 Deaderick St.
Nashville, TN 37243
Phone: 615-253-5688
Fax: 615-532-9940

8. Authorizing Signature:
No Change

Attachment #1 Transition Plan
None

APPENDIX A: WAIVER ADMINISTRATION AND OPERATION

1. State line of Authority

~~Division of Intellectual Disabilities Services (DIDS)~~ Department of Intellectual and Developmental Disabilities (DIDD)

2. Oversight Performance:

b. The Self Determination Waiver Program is operated by the ~~Division of Intellectual Disabilities Services (DIDS)~~Department of Intellectual and Developmental Disabilities (DIDD) through an interagency agreement with the Bureau of TennCare, Department of Finance and Administration. The Tennessee Department of Finance and Administration is designated as the Single State Medicaid Agency for the State of Tennessee. The Bureau of TennCare is the state's medical assistance unit and is located within the Department of Finance and Administration. The TennCare Director, who serves as a Deputy to the Commissioner of the Department of Finance and Administration, is the State Medicaid Director and exercises legal authority in the administration and supervision of the Medicaid State Plan and the TennCare 1115 Demonstration Waiver, and issues policies, rules and regulations on program matters. TennCare is accountable for oversight of this waiver program and retains the responsibility for approval of policies and promulgation of rules governing this waiver.

~~DIDS~~ DIDD is responsible for the operational management of the waiver on a day-to-day basis and is accountable to the State Medicaid agency which ensures that the waiver operates in accordance with federal waiver assurances. Responsibility is delegated to ~~DIDS~~ DIDD and monitored by TennCare for waiver enrollment, level of care reevaluations, development of the plan of care, prior authorization of waiver services, enrollment of qualified providers, and certain quality assurance activities. TennCare exercises administrative authority and supervision of these functions through the interagency agreement which is reviewed on an annual basis to ensure that it accurately reflects expectations and incorporates any program changes implemented as a result of recent waiver amendments or changes in state or federal requirements. TennCare promulgates state waiver rules and approves the following when applicable to daily operational

management of the waiver: all ~~DIDS~~DIDD policies and procedures, Provider Manual revisions, provider rate changes, mass communications to providers and service recipients, and other documents impacting waiver program operations prior to implementation. In addition to ongoing informal communication processes, monthly meetings between TennCare and ~~DIDS~~DIDD ensure adequate TennCare oversight. Monthly meetings include:

- The Policy Meeting: TennCare and ~~DIDS~~DIDD staff review ~~DIDS~~DIDD policies and stakeholder memorandums under development, including the status of those under review at TennCare; Provider Manual revisions; changes in TennCare rules and policy; and the status of waiver applications, as appropriate. This forum is also used as a mechanism for ~~DIDS~~DIDD to obtain TennCare policy interpretations and for TennCare to assign responsibility for CMS deliverables.

~~• The Protection From Harm Meeting: TennCare and DIDS~~DIDD ~~staff review complaints and complaint resolution issues, information about service recipient deaths, information about medication errors, and investigations of critical incidents (e.g., abuse, neglect, and exploitation).~~

- The ~~TennCare/DIDS~~DIDD Statewide Continuous Quality Improvement ~~Review~~ Meeting: ~~DIDS~~DIDD and TennCare staff review identified data and reporting issues, as well as findings resulting from TennCare Quality Assurance activities (e.g., targeted Reviews, utilization reviews, fiscal audits) and discuss appropriate corrective actions.

- The Abuse Registry Committee Meeting: A TennCare representative serves on the Abuse Registry Committee and participates in the review of substantiated allegations of abuse, neglect, and exploitation. The committee decides when individuals will be referred for placement on the Tennessee Department of Health Abuse Registry.

- The Statewide and Regional Planning and Policy Council Meetings: ~~DIDS~~DIDD and TennCare staff participate in meetings with stakeholders including service recipients and service recipient family members, a variety of provider representatives enrolled as waiver service providers (e.g., clinical service providers, residential/day providers, support coordination providers, representatives from service recipient and provider advocacy organizations, and other stakeholders. Planning and Policy Council members are routinely advised of the status of lawsuits; program expenditures and the state's budget situation; and expected changes in policy, provider requirements, and provider reimbursement; waiver application and amendment status; and other issues impacting service delivery and program operations.

- The State Quality Management Committee Meeting: ~~TennCare and DIDS~~DIDD management staff participates in the State Quality Management Meeting to discuss performance measure data and root causes for compliance issues identified. Systemic issues are identified and appropriate systemic remedial actions are also discussed. The ~~DIDS~~DIDD Monthly Quality Management Report and TennCare discovery and remediation summary reports provide the data utilized for identification of issues.

3. Use of Contracted Entities:

~~DIDS~~DIDD ~~and TennCare have~~ has an administrative contract, reviewed and approved by TennCare, with a financial management services company to make payment for participant-managed services, handle federal/state taxes and other payroll or benefits related to the employment of the participant-managed worker(s), and help manage the individual's budget. In addition, participants have access to independent support broker services through this administrative contract.

4. Role of Local/Regional Non-State:
No Change

5. Responsibility for Assessment:

The State of Tennessee ~~Division of Intellectual Disabilities Services (DIDS)~~ Department of Intellectual and Developmental Disabilities (DIDD), is responsible for performance oversight for Medicaid Home and Community-Based Services waiver contracted providers. This includes oversight of the company contracted by ~~DIDS~~DIDD to manage the statewide scoring for the uniform assessment of need (e.g., Inventory for Client and Agency Planning {ICAP} or the Supports Intensity Scale {SIS}) and of the company contracted by ~~DIDS~~DIDD and TennCare to provide fiscal management and support brokerage services.

TennCare oversees and evaluates ~~DIDS '~~DIDD's effectiveness in monitoring the performance of contracted service providers and administrative entities though analysis of performance measure data, review of remediation activities, receipt of information during regularly scheduled meetings, reviews of policy and other program materials and documents, and other quality assurance activities as appropriate (e.g. financial audits, follow-along and follow behind reviews, targeted reviews).

6. Assessment Methods and Frequency:

On an annual basis, the ~~Division of Intellectual Disabilities Services (DIDS)~~ Department of Intellectual and Developmental Disabilities (DIDD) Office of Quality Management ~~Internal Audit~~, Fiscal Accountability Review Unit performs audits of the contractor that manages the statewide scoring for the uniform assessment (e.g., Inventory for Client and Agency Planning {ICAP} or the Supports Intensity Scale {SIS}) and of the contractor that provides financial management and support brokerage services. During on-site surveys, auditors assess the contractor's effectiveness in performing contracted waiver administrative functions in accordance with waiver requirements and the terms and conditions of the contract. If performance issues are identified, the contractor is required to submit an acceptable corrective action plan. ~~DIDS~~DIDD performs follow up activities to ensure that the corrective action plan is implemented and successfully resolves performance issues. TennCare is provided a copy of the audit reports and subsequent corrective action plans for review.

TennCare has responsibility for final approval of the language contained in the three-way provider agreement template, which specifies provider requirements and responsibilities as well as ~~DIDS~~DIDD and TennCare responsibilities in administration/operation of the waiver program. TennCare reviews individual waiver provider and administrative contracts prior to execution and is a signatory on these provider agreements.

TennCare reviews monthly Qualified Provider performance measure data collected and compiled by ~~DIDS~~DIDD. Information contained in the monthly performance measure reports includes compliance issues discovered and remedial actions taken. TennCare determines if the appropriate remedial actions have been taken, and if not, requests that ~~DIDS~~DIDD provide additional information and/or take additional remedial action.

~~DIDS~~DIDD conducts Provider Performance Surveys. Reports containing survey findings and domain scores are available for TennCare review.

TennCare reviews monthly ~~DIDS~~DIDD summary reports containing descriptive information about investigations completed. Individual detailed investigation reports are available to TennCare for review.

In addition, TennCare may initiate targeted quality assurance activities (e.g., follow-along or follow-behind surveys, or fiscal audits) as determined appropriate.

7. Distribution of Waiver Operational and Administrative Functions:
No Change.

APPENDIX A:
Quality Improvement: Administrative Authority of the Single State Medicaid Agency
Methods for Discovery: Administrative Authority

a.i.1. Number and percentage of waiver policies/procedures developed by ~~DIDS~~DIDD that were approved by TennCare prior to implementation. [Interagency Contract section A.1.b.] Percentage = number of waiver policies/procedures approved by TennCare prior to implementation/ total number of waiver policies/procedures implemented.
a.i.2. Number and percentage of individual findings regarding level of care reevaluation that were appropriately and timely remediated by ~~DIDS~~DIDD. [Interagency Contract section A.1.h.] Percentage = number of level of care reevaluation findings appropriately and timely remediated/ total number of level of care reevaluation findings identified.
a.i.3. Number and percentage of individual findings regarding provider (including staff) qualifications that were appropriately and timely remediated by ~~DIDS~~DIDD . [Interagency Contract section A.1.n & A.2.a.(2)] Percentage = number of provider qualification issues appropriately and timely remediated/ total number of provider qualification issues identified.
a.i.4. ~~# and % of Individual Support Plans that did not include outcomes, measureable action steps, or the things important to the participant that were appropriately and timely remediated by DIDS. [Interagency Contract section A.1.g & A.1.i] Percentage = number of deficient Individual Support Plans appropriately and timely remediated/ total # of deficient Individual Support Plans identified.~~ # and % of individual findings regarding Individual Support Plans that were appropriately and timely remediated by DIDD. Percentage = # of individual findings regarding Individual Support Plans that were appropriately and timely addressed/ total # of individual findings regarding Individual Support Plans.
~~a.i.5. Number and percentage of untimely Individual Support Plans annual renewals that were appropriately and timely remediated by DIDS. [Interagency Contract section A.1.g & A.1.i.] Percentage = number of untimely Individual Support Plans annual renewals/updates appropriately and timely remediated / total number of untimely Individual Support Plans annual renewals identified.~~
a.i.6. # & % of participants not offered choice (of waiver services vs institutional care, available waiver services, or qualified waiver service providers) for whom remediation was appropriately and timely completed by ~~DIDS~~DIDD. [Interagency Contract sec. A.1.d & A.2.d.(2)] % = # of participants not offered choice with appropriate and timely remediation/total # of participants not offered choice.
a.i.7. Number and percentage of substantiated cases of abuse, neglect and exploitation that were appropriately and timely remediated by ~~DIDS~~ DIDD. [Interagency Contract section A.2.a.) Percentage = number of substantiated cases of abuse, neglect and exploitation appropriately and timely remediated / total number of substantiated cases of ANE.
a.i.8. Number and percentage of inappropriate provider claims identified via post-payment review processes that were appropriately and timely remediated by ~~DIDS~~ DIDD. [Interagency Contract section A.2.b.] Percentage = number of individual inappropriate claims that were appropriately and timely remediated / total number of inappropriate claims identified via post-payment review processes.

b. Methods for remediations / Fixing Individual problems:

i. Performance Measure a.i.1: The TennCare Interagency Agreement specifies that ~~DIDS~~ DIDD may not implement policy prior to TennCare approval. TennCare policy reviews will be documented in the TennCare Policy Review Log as well as in ~~DIDS~~' DIDD Monthly Quality Management and Discovery Reports. Each ~~DIDS~~ DIDD policy distributed notes the date of TennCare approval within the document. TennCare will monitor compliance with this subassurance through analysis of monthly data reports, information presented during monthly TennCare/~~DIDS~~ DIDD meetings, and other quality assurance activities (e.g., survey follow-along or follow-behind, audits) conducted as determined appropriate. Upon discovery of a policy that was not prior-approved, TennCare will provide written notification to ~~DIDS~~ DIDD that the policy must be submitted to TennCare for approval and will not be effective until such approval is obtained. TennCare will perform ~~an expedited~~ a review of the new or revised policy, and will advise ~~DIDS~~ DIDD if additional revisions are needed as a result of TennCare review. Approval will be granted when TennCare-requested final edits have been made. The effective date of an approved new or revised policy will be a date after TennCare approval is obtained, unless TennCare determines it appropriate to approve the policy for a retroactive date. Failure to obtain policy prior-approval will be brought to the attention of the ~~DIDS~~DIDD Commissioner, the ~~DIDS Assistant Commissioner of Policy and Planning~~ DIDD Deputy Commissioner of Policy and Innovation, and other ~~DIDS~~DIDD staff, as applicable. TennCare may assess monetary sanctions against ~~DIDS~~DIDD, require additional ~~DIDS~~DIDD staff training, conduct additional monitoring and/or require the submission of additional data to ensure 100% compliance with this subassurance.

Performance Measure a.i.2. through a.i.8.: Issues requiring individual remediation will be discovered primarily through analysis of ~~DIDS~~DIDD performance measure discovery data files and ~~DIDS~~DIDD Quality Management Reports. TennCare will hold ~~DIDS~~DIDD accountable for timely remediation of all individual issues identified. TennCare routinely monitors ~~DIDS~~ DIDD monthly remediation reports to determine if acceptable remedial activities have been completed. ~~DIDS~~DIDD is notified monthly of any remediations determined unacceptable and is required to provide additional information and/or complete additional remediation activities until TennCare can determine that the issue has been resolved. ~~DIDS~~DIDD is required to remediate all individual issues identified within a targeted time-frame of 30 days. Remediation Reports contain data indicating the number of compliance issues for which remediation was completed within 30 days.

Individual Remediation Data Aggregation: ~~DIDS~~DIDD has developed a data flow document which identifies data collection, reporting, and aggregation tasks that must be completed to generate the required reports for submission to TennCare. For each task, due dates are specified. Responsible ~~DIDS~~DIDD staff and back-up staff are identified for each task. Designated ~~DIDS~~DIDD Central Office staff compile the data collected and entered by regional and central office staff into ~~DIDS~~DIDD databases to create data files that are posted for TennCare analysis and aggregation. In addition, ~~DIDS~~DIDD generates a Quality Management Report using the data collected and reported. The Quality Management Report is submitted to TennCare each month and information contained therein is reviewed during monthly State Quality Management Committee Meetings. ~~TennCare compiles monthly Compliance Summary Reports from DIDS data, which are also reviewed and analyzed during State Quality Management Meetings. Reports include information regarding the number of sample reviews completed, compliance percentages, individual remediation activities and timeframes required for remediation. Reports include cumulative totals for the waiver year to date. TennCare Compliance Summary Reports are distributed to DIDS management staff for discussion and analysis during monthly State Quality Management Committee Meetings.~~

APPENDIX B: PARTICIPANT ACCESS AND ELIGIBILITY

B-1: Specification of the Waiver Target Group(s)
b. Additional Criteria

Enrollment is further limited to individuals who:

a. Meet TennCare ICF/IID level of care criteria (TennCare Rule 1200-13-1-.15) and financial eligibility criteria and have a PreAdmission Evaluation approved by TennCare;

b. Have been assessed and found to:

i. Have mental retardation (i.e., intellectual disability) manifested before eighteen (18) years of age, as specified in Tennessee State law (Tennessee Code Annotated, Title 33-1-101); or,

ii. Have a developmental disability, which is defined as a condition of substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in mental retardation (i.e., intellectual disability)and be a child five (5) years of age or younger; and

c. Do not require residential waiver services (e.g., residential habilitation, supported living) and have an established non-institutional place of residence where they live with their family, a non-related caregiver or in their own home.

c. Transition of Individuals Affected by Maximum Age Limitation.

It is often difficult to diagnose children under the age of 5 as having mental retardation (i.e. intellectual disability) as defined in Tennessee Code Annotated, Title 33-1-101.

Children who enter the waiver between the ages of 0-5 with a diagnosis of developmental disability, are evaluated before age 6 to determine if they have a condition of mental retardation (i.e. intellectual disability) as defined in Tennessee Code Annotated, Title 33-1-101. Upon attaining age six (6) years, if a child in the Self-Determination Waiver is found to no longer meet level of care, the Medicaid agency will ensure the continuation of EPSDT services for children who remain Medicaid eligible, and for both Medicaid-eligible and non-Medicaid-eligible children, help identify, through other community resources, other types of assistance that can help address the child and family's ongoing support needs.

B-2: Individual Cost Limit

a. Individual Cost Limit.
Cost Limit lower than institutional costs. The individual budget limit is $30,000 per program year per individual. The $30,000 limit provides for up to $23,000 per year per individual in the Supports for Community Living Category, and $7,000 per year per individual in the Professional and Technical Support Services Category. Exceptions may be granted to increase the $23,000 or the $7,000 limit so long as the $30,000 combined limit is not exceeded.

When a participant's budget reaches $30,000, emergency assistance services may be provided to the participant in an amount up to $6,000 in order to provide an extra measure of protection when the participant experiences a crisis or emergency situation that threatens his/her health and well-being.

The total of all waiver services shall not exceed $36,000 per year per participant.

The target population for this waiver is persons who live with their family, a non-related caregiver or in their own home. These are individuals who have support systems in place, and this waiver is intended to support, but not supplant, that natural caregiving system. Because many of the support needs are met by family and other caregivers, based on the State's experience, this level of service is sufficient to meet the needs of this target population.

However, should the person's needs change, or should the natural support system collapse, provisions exist for the individual to transition to the other Statewide HCBS Waiver for persons with an intellectual disability ~~mental retardation~~ which offers a more comprehensive package of benefits.

B-2: Individual Cost Limit
b. Method of Implementation of the Individual Cost Limit.

Prior to entrance into the Self-Determination Waiver Program, an individualized assessment of need is conducted by the ~~DIDS~~ DIDD case manager. The purpose of this assessment is to identify the service needs and to project the total cost for the services in order to determine whether the needs of the person can be satisfactorily met in a manner that assures the individual's health and welfare.

c. Participant Safeguards. Under the Self-Determination Waiver Program, each participant has an individual budget based on an assessment of the participant's need for the services available in the program. If the cost for all waiver services, including Emergency Assistance services, reaches or is projected to reach the absolute waiver limit of $36,000 per year per participant and the participant's health and welfare cannot be ensured after seeking funding through non-waiver resources, the participant will be given an opportunity to request services through another existing Home and Community Based Services waiver program for which the participant may be eligible or, as appropriate, will be assisted in seeking admission to an ICF/~~MR~~IID.

B-3: Number of Individuals Served
Unduplicated Number of Participants.

f. Selection of Entrants to the Waiver.

Entry to the Tennessee Self-Determination Waiver Program is offered to Tennessee residents in the target populations who:

1. Meet Medicaid financial eligibility criteria in one of the specified eligibility categories;

2. Meet Intermediate Care Facility for ~~Mentally Retarded~~ individuals with Intellectual Disabilities (ICF/~~MR~~IID) level of care criteria verified by the approval process of the Pre-Admission Evaluation (PAE);

3. Meet the requirements of Tennessee Code Annotated, TennCare Rule Chapter 1200-13-1-.29 which establishes the CMS-approved requirements for the Self-Determination Waiver Program, defines mental retardation (i.e. intellectual disability), describes the intake and enrollment process, the disenrollment process, specifies waiver administration is conducted by the ~~Division of Intellectual Disabilities Services~~ Department of Intellectual and Developmental Disabilities, describes reimbursement for services and appeal rights of participants;

4. Have adequate caregiver support to assure health, safety, and welfare;

5. Have needs which can be met through the budget limits established for the Self-Determination Waiver Program; and

6. Do not need staff-supported residential services.

The process for selection of entrants to the waiver includes a comprehensive assessment by the case manager of the individual's social and family situation, health care status, need for assistance with activities of daily living, and caregiver support. Review of records may include the individual's medical records, psychological evaluation, the uniform assessment (e.g. Inventory for Client and Agency Planning {ICAP} or Supports Intensity Scale {SIS}) if one is available, and other records. The current availability of caregiver support is assessed, including the number of available caregivers and whether or not the caregivers are supporting more than one individual. Priority levels are determined based on the immediacy of need for caregiver support and need for waiver services.

The state will serve the lesser of the number of unduplicated users specified for each year, or the number it is able to serve within its appropriation each year.

B-6: Evaluation/Reevaluation of Level of Care

b. Responsibility for Performing Evaluations and Reevaluations.

1. The Bureau of TennCare, the State's Medical Assistance Unit, which is within the Department of Finance and Administration, is responsible for performing the initial level of care evaluations (PAE's).

2. The ~~Division of Intellectual Disabilities Services (DIDS),~~ Department of Intellectual and Developmental Disabilities (DIDD) ~~also within Department of Finance and Administration~~, is responsible for the annual level of care reevaluation.

d. Level of Care Criteria.

Initial Level of Care Criteria

The State's level of care criteria for the Self-Determination Waiver specify that the applicant must meet ICF/~~MR~~IID level of care criteria, as verified by approval of the Pre-Admission Evaluation (PAE) for ICF/~~MR~~IID Care (the State's level of care assessment tool). Those criteria are as follows:

1. Have a diagnosis of Mental Retardation (i.e. intellectual disability) manifested before eighteen (18) years of age or a Developmental Disability, which is defined as a condition of substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in mental retardation and be a child five (5) years of age or younger; and
2. Require a program of specialized services for mental retardation or related conditions provided under the supervision of a Qualified ~~mental retardation~~ Intellectual Disabilities Professional (Q~~MR~~IDP); and

3. Have a significant deficit or impairment in adaptive functioning in one of the following areas: communication, comprehension, behavior, or activities of daily living (e.g., toileting, bathing, eating, dressing/grooming, transfer, mobility).

In addition, the person must have been assessed as having needs that can be satisfactorily met by the services available through the Self-Determination Waiver Program in a manner that assures the individual's health and welfare.

Level of Care Criteria for Reevaluation

There are four level of care requirements that must be met for continued enrollment in the waiver during the reevaluation process. The enrollee must:

1. Need the level of care being provided and would, but for the provision of waiver services, otherwise be institutionalized in an ICF/~~MR~~IID.

2. Require services to enhance functional ability or to prevent or delay the deterioration or loss of functional ability.

3. Have a significant deficit in impairment in adaptive functioning involving communication, comprehension, behavior, or activities of daily living (i.e., toileting, bathing, eating, dressing/grooming, transfer, or mobility); and

4. Require a program of specialized supports and services provided under supervision of a Qualified ~~Mental Retardation~~ Intellectual Disabilities Professional.

f. Process for Level of Care Evaluation/Reevaluation:

The initial evaluation requires a Pre-Admission Evaluation (PAE) to be completed.

Applicants are screened by the ~~Division of Intellectual Disabilities Services (DIDS~~) Department of Intellectual and Developmental Disabilities (DIDD) to determine that they have a diagnosis of mental retardation (i.e. intellectual disability) prior to age 18. When an applicant is determined to be likely to require the level of care provided by an ICF/~~MR~~IID,~~ DIDS~~ DIDD informs the individual or the individual's representative of any feasible alternatives under the waiver program and offers the choice of either institutional or waiver services.

~~DIDS~~DIDD conducts a pre-enrollment assessment. ~~DIDS~~DIDD submits the Pre-Admission Evaluation (PAE) for ICF/~~MR~~IID Care to the Bureau of TennCare, the state Medicaid agency. The Bureau of TennCare determines whether the person meets the ICF/~~MR~~IID level of care.

~~DIDS~~DIDD is responsible for completing annual reevaluations. A physician, a registered nurse, or a Qualified ~~Mental Retardation~~ Intellectual Disabilities Professional must attest that the participant meets the four requirements for reevaluation described in (d.) above.

h. Qualifications of Individuals Who Perform Reevaluations.

Qualifications of professionals who conduct annual reevaluations are:
- Physician, either a D.O. or M.D.;
- Registered Nurse licensed in the State of Tennessee; or
- Qualified ~~Mental Retardation~~Intellectual Disabilities Professional (Q~~MR~~P QIDP), as defined in 42 CFR 483.430(a)

i. Procedures to Ensure Timely Reevaluations.

Each ~~DIDS~~ DIDD regional office tracks and monitors annual level of care reevaluations due dates through the ~~DIDS~~ DIDD Client Information Tracking System on a monthly basis to ensure timely receipt.

j. Maintenance of Evaluation/Reevaluation Records

Initial Level of Care Evaluations: Initial Level of Care evaluation determinations are made by the Bureau of TennCare which maintains all applicable written and electronic documentation for a minimum of 3 years.

Annual Level of Care Reevaluations: Annual Level of Care Reevaluations are conducted by ~~DIDS~~ DIDD, which maintains all applicable written and electronic documentation for a minimum of 3 years.

Appendix B: Evaluation/Reevaluation of Level of Care
Quality Improvement: Level of Care

a.i.a.2. Number and percentage of new waiver participants for whom level of care eligibility was approved prior to enrollment in the waiver. Percentage = number of newly enrolled waiver participants for whom level of care eligibility was approved prior to enrollment in the waiver/total number of newly enrolled waiver participants.
a.i.b.1. Number and percentage of waiver participants who had an annual LOC reevaluation completed within 12 months of their initial evaluation or last annual reevaluation. Percentage = number of waiver participants with timely annual LOC reevaluations/ number of waiver participants in the sample.
a.i.c.1. Number and percentage of initial level of care determinations made by a qualified evaluator (i.e. Registered Nurse). Percentage = number of LOC determinations made by a qualified evaluator / total number of LOC determinations.
~~a.i.c.2. Number and percentage of initial level of care applications submitted on an approved PreAdmission Evaluation (PAE) form. Percentage = number of initial level of care applications submitted on an approved PAE form / total number of level of care applications submitted.~~
a.i.c.3. Number and percentage of initial level of care determinations made for which LOC criteria were accurately and appropriately applied. Percentage = number of initial LOC determinations made for which LOC criteria were accurately and appropriately applied/ total number of initial LOC determinations.
~~a.i.c.4. Number and percentage of LOC reevaluations performed by a qualified evaluator (i.e., physician, registered nurse, or qualified mental retardation professional). Percentage = number of LOC reevaluations performed by a qualified evaluator / total number of waiver participants in the sample.~~
~~a.i.c.5. Number and percentage of LOC reevaluations that were completed using the correct form. Percentage = number of LOC reevaluations that were completed using the correct form / total number of waiver participants in the sample.~~
a.i.c.6. Number and percentage of LOC reevaluations made for which LOC criteria were accurately and appropriately applied. Percentage = number of LOC reevaluations made for which LOC criteria were accurately and appropriately applied / total number of waiver participants in the sample.

a.i.c.7. Number and percentage of ICF/~~MR~~IID level of care eligibility determinations made within 8 working days of receipt of application. Percentage = Number of determinations made within 8 days/ total number of applications received.

ii. Performance Measures a.i.b.1. and a.i.c.4. through a.i.c.6.: A representative sample of waiver participants will be generated at the beginning of the waiver year. The sample will be divided as evenly as possible to collect data during the following twelve (12) months. For each waiver participant included in the sample, Individual Record Reviews will be conducted by designated ~~DIDS~~DIDD Regional Office staff to obtain the information needed to determine compliance with this performance measure.

Performance Measures a.i.c.3.: TennCare will select a monthly sample of PAEs reviewed for ICF/~~MR~~IID level of care during the previous month. For each PAE in the sample, a PAE Nurse who was not involved in the original review will be assigned to conduct a "follow-behind" review to ensure ICF/~~MR~~IID level of care criteria were appropriately utilized in approving or denying the PAE.

1. Methods for Remediation/Fixing Individual Problems

b.i. Performance Measures a.i.a.2.: The TennCare MMIS Edit 2008 does not allow payment for waiver services until an approved Pre-Admission Evaluation (PAE) is entered into the MMIS system (the PAE is the Tennessee level of care determination form). Edit reports generated from the MMIS will be utilized for TennCare staff to identify instances where claims for waiver services were denied due to the absence of a PAE file. When such instances are discovered, TennCare staff will investigate whether the unit neglected to enter the PAE information into the system or whether a claim was submitted when there was no current approved PAE on file. If TennCare staff failed to enter the PAE information in the system, the error will be corrected upon discovery and staff who made the error will be counseled as appropriate. If a claim was submitted before a PAE was approved or submitted or for an expired PAE, ~~DIDS~~DIDD will be notified via the Remittance Advice Report. ~~DIDS~~DIDD will be required to submit a PAE, update an expired PAE, or await approval of a pending PAE, as applicable, prior to resubmitting and receiving payment for the claim. TennCare's goal for resolution of claims denials related to "no PAE on file" is 30 days.

Performance Measures a.i.b.1.: When ~~DIDS~~DIDD Regional Office staff discover that a level of care redetermination was not conducted within a calendar year of an initial level of care determination or the previous level of care redetermination, the Regional Case Management Director will be notified of the problem and the need for expedient corrective action within 2 working days. The ~~DIDS~~DIDD Case Management Director will be responsible for ensuring that the evaluation is completed by the ~~DIDS~~DIDD case manager within three working days of notification. The ~~DIDS~~DIDD Case Management Director will also be required to determine reasons for the delay and initiate necessary individual staff disciplinary actions within 30 days of notice. Staff disciplinary actions may include training or retraining, verbal or written warnings, or suspension or termination. ~~DIDS~~DIDD Regional Quality Assurance Review Teams will produce findings reports that will be submitted to ~~DIDS~~DIDD Regional Office Compliance staff for data compilation. ~~DIDS~~DIDD Regional Case Management Directors will be responsible for reporting corrective actions and dates to ~~DIDS~~DIDD Regional Compliance staff. Regional data will be reported to Central Office Compliance Unit staff.

Performance Measure a.i.c.1.: Only registered nurses employed and trained by TennCare to review PAEs may render a level of care decision. Only those PAEs approved by TennCare review nurses are entered into the MMIS to allow payment of claims. Upon discovery that an unqualified individual approved or denied a PAE, TennCare will assign a qualified TennCare PAE nurse to complete a re-review of the application within 8 working days. The corrected PAE with the signature of the qualified TennCare PAE nurse who approved the PAE upon re-review will be forwarded to the applicant and appropriate Case Manager within three working days of the re-review decision being made, with a cover letter explaining that the previous PAE is invalid and that the new PAE, signed by a qualified TennCare PAE reviewer, should be used to demonstrate medical eligibility for services. TennCare will then apply an end-date to the MMIS segment pertaining to the PAE approved in error, so that claims cannot be billed using that PAE. If an original PAE review results in approval by an unqualified reviewer, and such approval is determined to be in error upon re-review, TennCare will send a corrected denied PAE (including the signature of the qualified TennCare PAE reviewer) to the appropriate ~~DIDS~~DIDD case manager and a notice of denial to the waiver participant, copied to the appropriate Support Coordinator. Both will be issued within three working days of the new determination being made. The notice of denial will include a description of applicable appeal rights. A cover letter will be attached advising the applicant that a wrongful determination was made by an unqualified reviewer and that ~~DIDS~~DIDD will be required to begin disenrollment procedures upon exhaustion of appeal rights. ~~DIDS~~DIDD will complete and issue a waiver disenrollment notice (reviewed by TennCare prior to issuance) if no appeal is received within 30 days of the waiver participant's receipt of the erroneous PAE approval notice. If an appeal is received within 30 days of the waiver participant's receipt of the notice and a fair hearing is held, ~~DIDS~~DIDD will issue notice of disenrollment upon receipt of a final order indicating that the applicant is ineligible for waiver services. In the event that the applicant is approved via the fair hearing, waiver funds will be used to pay for service claims. If the applicant is finally determined to be ineligible through appeal processes, the state will not claim FFP for reimbursement of services rendered prior to disenrollment. TennCare will track and report the number of PAEs re-reviewed due to prior disposition by an unqualified reviewer as well as approvals, denials, and appeals generated by re-reviews.

Performance Measures a.i.c.7.: When TennCare review of the PAE process determines that ICF/~~MR~~IID PAEs were not completed within 8 calendar days of receipt, the PAE Unit Supervisor will verify that the PAE has been properly completed, determine why the PAE was not completed timely, and counsel staff and/or adjust operational procedures as necessary. Remediation is expected within a targeted time frame of 30 days.

B-7: Freedom of Choice
a. procedures.

FREEDOM OF CHOICE

1. When an individual is determined to be likely to require a level of care provided in an institutional setting and the waiver capacity has not reached the specified cap of unduplicated participants for the year, the individual or his or her legal representative will be:

a. informed of any feasible alternatives under the waiver; and

b. given the choice of either institutional or Home and Community-Based services.

PROCESS:

The following describes the agency's procedure(s) for informing eligible individuals of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services:

When an individual is determined to be likely to require the level of care provided by an ICF/~~MR~~ IID, ~~DIDS~~DIDD shall inform the individual or the individual's legal representative of any feasible alternatives available under the waiver program, including a description of the waiver services and names and addresses of available qualified providers, and shall offer the choice of either institutional or waiver services.

Notice to the individual shall contain a simple explanation of the waiver and waiver services; a statement that participation in the Waiver is voluntary; and notification of the opportunity to apply for enrollment in the Waiver and an explanation of the procedures for enrollment. The Freedom of Choice form shall be explained and the signature of the person to receive waiver services or the legal representative will be obtained on the Freedom of Choice form, which will be completed prior to admission into the waiver program.

b. Maintenance of forms.

Copies of freedom of choice documentation are maintained in the following location(s):

The Freedom of Choice documentation will be maintained by ~~DIDS~~DIDD.

B-8: Access to Services by Limited English Proficiency Persons

For Individuals with Limited English Proficiency (LEP)

The Bureau of TennCare, the Department of Human Services, and the ~~Division of Intellectual Disabilities Services (DIDS)~~ Department of Intellectual and Developmental Disabilities (DIDD) provide a number of options to assist individuals with Limited English Proficiency (LEP) as they navigate the application process for TennCare eligibility.

The Bureau of TennCare and the Department of Human Services provide eligibility applications and mail notices in English and Spanish. An insert in each TennCare mailing provides information in each of the following languages and a toll-free phone number that individuals may call for translation assistance: Arabic, Kurdish-Bandinani, Kurdish-Sorani, Bosnian, and Vietnamese. Translation services are provided by the TennCare Advocacy Program, a program of Health Assist Tennessee. In addition to translation services, the TennCare Advocacy Program also assists TennCare enrollees and applicants with TennCare questions or problems, and can direct enrollees and applicants to other local community resources for translation and other assistance. ~~DIDS~~DIDD also provides translation services as needed.

All notices contain the numbers of the Family Assistance Service Centers. Through that number a connection can be made with AT&T Language Line for translation services if needed.

The Department of Human Services provides a list of accommodations that are made available to the TennCare population. These accommodations include:

•Letting the service recipient/applicant designate a third party to represent him/her during the eligibility process;

•Conducting the interviews over the phone;

•Conducting the interview at an alternative site that is easier for the service recipient/applicant to access;

•Conducting the interview outside of normal working hours;

•In extreme cases, conducting the interview in the service recipient's home.

Appendix C: Participant Services

C-1 SERVICE DEFINITIONS / MODIFICATIONS:

Respite shall mean services provided to a service recipient when unpaid caregivers are absent or incapacitated due to death, hospitalization, illness, or injury, or when unpaid caregivers need relief from routine caregiving responsibilities. Respite may be provided in the service recipient's place of residence, in a Family Model Residential Support home, in a Medicaid-certified ICF/IID, in a home operated by a licensed residential provider, in a licensed respite care facility, or in the home of an approved respite provider. The Respite provider may also accompany the service recipient on short outings for exercise, recreation, shopping or other purposes while providing respite care.

Reimbursement for Respite shall not include payment for Respite provided by the spouse of a person supported or family member or relative (whether by birth or marriage) who resides with the person supported in the home. ~~Respite services are not intended to substitute for services such as Day Services or Personal Assistance Services~~. The Respite provider and provider staff shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Respite provided by such individuals. Reimbursement for Respite shall not include payment for Respite provided by any other individual who has been appointed as the conservator for the person supported unless so permitted in the Order for Conservatorship. Family members who provide Respite must meet the same standards as providers who are unrelated to the person supported, including implementing services as specified in the individual support plan (ISP).

When less than 8 hours of respite services is needed in a day, the unit of reimbursement shall be per 15 minutes. When 8 hours or more of respite services are needed in a day, the unit of reimbursement shall be per day.

Level 1 per day reimbursement shall be for persons requiring at least 8 hours, but less than 16 hours of respite services in a day. Level 2 per day reimbursement shall be for persons requiring 24 hour respite services, but no awake overnight direct support staff. Level 3 per day reimbursement shall be for persons requiring 24 hour respite services with awake overnight direct support staff.

Respite shall be limited to a maximum of 30 days per person supported per year.

Family members are required to implement services as specified in the individual support plan (ISP). Reimbursement to family members shall be limited to forty hours per week per family member for self-directed services as well as those delivered by contracted provider agencies. The person's Circle of Support is responsible for determining if the use of family members to deliver paid care is the best choice for the person-supported and shall ensure that paid services

do not supplant natural supports that would otherwise be provided at no cost to the Medicaid program. ~~whether there is not an alternative provider to deliver the service.~~

Providers who receive the per diem reimbursement rate for Respite shall be responsible for the cost of any Day Services needed while the person is receiving Respite services.

Respite Services shall not be provided during the same time period that the person supported is receiving Personal Assistance Services, Day Services, or services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof.

Day Services

Day Services shall mean individualized services and supports that enable a person to acquire, retain, or improve skills in the area of self-care, sensory/motor development, socialization, daily living skills, communication, community living, and social skills. Day Service therapeutic objectives and action steps are outlined in the Individual Support Plan (ISP)/plan of care during the person-centered planning process. With the exception of employment that is staff supported, Day Services shall be provided only on weekdays during the day between the hours of 7:30 a.m. and 6:00 p.m. as specified in the ISP/plan of care. Day Services may be provided to persons as a separate service where permitted under service specifications described in this waiver.

Community-based Day Services are designed to enable the person to become more independent, integrated, and productive in the community as well as assist the person to build relationships and natural supports. Community-based Day Services are designed such that the person spends the majority of his/her time, while participating in this service, actively engaged in activities in the community (i.e., not facility-based or in-home day services). Supervision, monitoring, training, education, demonstration, or support is provided to assist with the acquisition of skills in the following areas: leisure activities and community/public events, utilizing community resources (e.g. public transportation), acquiring and maintaining employment, educational activities, hobbies, unpaid work experiences (e.g. volunteer opportunities), and maintaining contact with family and friends.

Facility-based Day Services are provided in a licensed day habilitation facility. A facility-based provider may provide services in community locations such as community recreation centers or job sites on occasion.

Supported Employment Day Services are provided in accordance with the following requirements:

a. A job coach employed by the Day Services provider shall be on-site at the work location and shall supervise the person; or
b. The Day Services provider shall oversee the person's supported employment services including on-site supervisors, and shall have a minimum of three contacts per week with the person including at least one contact per week at the work site, and shall have a job coach employed by the Day Services provider who is available on-call if needed to go to the work site.

In-home Day Services are provided in the person's residence if there is a health, behavioral, or other medical reason or if the person has chosen retirement and is unable to participate in services outside the home: such as, community-based, facility-based, and supportive employment.

Additional Requirements

Transportation of the person to and from the person's place of residence to the location where Day Services will be provided shall be the responsibility of the Day Services provider. With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program, transportation that is needed during the time that the person is receiving Day Services shall be the responsibility of the Day Services provider, and the cost of such transportation shall be considered to be included within the Day Services reimbursement rate.
Day Services shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID).
Day Services are not intended to replace services available through the Medicaid State Plan/TennCare program. Services provided by natural supports are not reimbursable and are excluded.

Day Services shall not replace services available under a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act. Day Services shall not be provided during the same time period that the person is receiving Personal Assistance Services, Respite Services, or services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof, or as a substitute for education services which are available pursuant to the Individual with Disabilities Education Act (IDEA), but which the person or his/her legal representative has elected to forego.

The reimbursement for Supported Employment Day Services shall not include incentive payments, subsidies, or unrelated vocational training expenses: such as,

a. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program.
b. Payments that are passed through to users of supported employment programs.
c. Payments for vocational training that is not directly related to a person's supported employment program.

Day Services shall be limited to a maximum of 5 days per week up to a maximum of 243 days per person per year. Family members who provide Day Services are required to implement services as specified in the Individual Support Plan (ISP). Reimbursement to family members shall be limited to forty (40) hours per week per family member for self-directed services as well as those delivered by contracted provider agencies. The person's Circle of Support is responsible for determining if the use of family members to deliver paid care is the best choice for the person supported and shall ensure that paid services do not supplant natural supports that would otherwise be provided at no cost to the Medicaid program.

Day Services shall be reimbursed in accordance with the requirements set forth herein.
The provider may receive the per diem reimbursement for Day Services if:

a. The person receives 6 hours of direct services comprised of any combination of Community-based, Facility-based, and or Supported Employment Day Services.

b. The person receives 6 hours of In-home Day Services. The reimbursement shall be the per diem rate for In-home Day Services.

c. The person receives at least 2 hours of Day Services and there is documentation that the person was unable to complete the full 6 hours of Day Services for reasons beyond the provider's control (e.g., sickness of the person).

Reimbursement for a combination of different Day Services (e.g., community-based, facility-based, and or supported employment) provided on the same day shall be made in accordance with the following:

a. If the person **receives up to or in excess of 6 hours** of a combination of Community-based and Facility-based Day Services, the reimbursement shall be the per diem reimbursement rate for the type of service provided for the greatest amount of time that day.

b. If the person **receives up to or in excess of 6 hours of a combination of Day services that includes Supported Employment,** the reimbursement shall be the per diem reimbursement rate for Supported Employment Day Services.

~~Day Services can be provided in settings such as specialized facilities licensed to provide Day Services, community centers or other community sites, or job sites.~~

~~This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for persons with Intellectual Disabilities) (ICFs/MR). A facility-based Day Services provider may on occasion provide facility-based Day Services in community locations other than in the provider's licensed facility. Examples include Special Olympics or field trips as approved by the Day Services provider and in accordance with the Individual Support Plan.~~

~~With the exception of employment that is staff supported, Day Services shall be provided only on weekdays during the day (i.e., between the hours of 7:30 a.m. and 6:00 p.m.), as specified in the plan of care. Day Services shall be limited to a maximum 5 days per week up to a maximum of 243 days per service recipient per year.~~

~~Transportation of the service recipient to and from the service recipient's place of residence to the location where Day Services will be provided shall be the responsibility of the Day Services provider. With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program, transportation that is needed during the time that the service recipient is receiving Day Services shall be the responsibility of the Day Services provider, and the cost of such transportation shall be considered to be included within the Day Services reimbursement rate.~~

~~A service recipient who is receiving Behavioral Respite Services shall not be eligible to receive Day Services as a separate service (since it would duplicate Day Services that are the responsibility of the Behavioral Respite Services provider).~~

~~Day Services shall not replace services available under a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act. For a service recipient receiving employment supports, reimbursement shall not be made for incentive payments, subsidies, or unrelated vocational training expenses such as the following:~~

~~•Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;~~

~~•Payments that are passed through to users of supported employment programs; or~~

~~•Payments for vocational training that is not directly related to a service recipient's supported employment program.~~

~~Day Services are not intended to replace services available through the Medicaid State Plan/TennCare program.~~

~~Day Services shall be reimbursed on a "per diem" basis in accordance with the requirements set forth herein.~~

~~For a service recipient who is receiving facility based or community based Day Services that day, the provider may receive the per diem reimbursement for Day Services if:~~

~~a. The service recipient receives 6 hours of direct services comprised of community based and/or facility based Day Services. (Services provided by natural supports are not reimbursable and are excluded.); or~~

~~b. The service recipient receives a total of 6 hours of Day Services comprised of community based or facility based direct services plus supported employment Day Services provided as described below;~~

~~c. There is documentation that the service recipient was unable to complete the full 6 hours for reasons beyond the control of the provider (e.g., sickness of the service recipient, behavioral issues involving the service recipient, refusal by the service recipient to continue, weather-related or environmental issues, medical appointments, family/conservator picked up the service recipient, service recipient or family/conservator requested 5 or fewer hours per day on an ongoing basis).,~~

~~Supported employment Day Services reimbursed on a per diem basis shall be provided in accordance with the following:~~

~~a. A job coach employed by the Day Services provider shall be on-site at the work location and shall supervise the service recipient; or~~

~~b. The Day Services provider shall oversee the service recipient's supported employment services including on-site supervisors, shall have a minimum of three contacts per week with the service recipient including at least one contact per week at the work site, and shall have a job coach employed by the Day Services provider who is available on call if needed to go to the work site.~~

~~For a service recipient who is receiving supported employment Day Services that day, the provider may receive the per diem reimbursement if:~~

~~a. The service recipient receives supported employment Day Services as described above and receives either 6 hours of supported employment Day Services or 6 hours of a combination of supported employment Day Services and community based and/or facility based Day Services.~~

~~b. there is documentation that the service recipient was unable to complete the full 6 hours of supported employment Day Services (or, if applicable, 6 hours of a combination of supported employment Day Services and community based and/or facility based Day Services) for reasons beyond the control of the provider (e.g., sickness of the service recipient, behavioral issues involving the service recipient, refusal by the service recipient to continue, weather-related or environmental issues, medical appointments, family/conservator picked up the service recipient; service recipient or family/conservator requested 5 or fewer hours per day on an ongoing basis).~~

~~Reimbursement for a combination of different Day Services provided on the same day shall be made in accordance with the following:~~

~~• If the service recipient receives up to 6 hours of a combination of community-based Day Services and facility-based Day Services on the same day, the reimbursement shall be the per diem reimbursement rate for the type of service (i.e., community-based or facility-based) provided to the service recipient for the greatest amount of time that day.~~

~~• If the service recipient receives more than 6 hours of a combination of community-based Day Services and facility-based Day Services on the same day, the reimbursement shall be the per diem reimbursement rate for the type of service (i.e., community-based or facility-based) provided to the service recipient for the greatest amount of that day.~~

~~• If the service recipient receives a combination of supported employment Day Services with either community-based Day Services or facility-based Day Services on the same day, the reimbursement shall be the per diem reimbursement rate for supported employment Day Services.~~

~~Day Services shall be limited to a maximum of 243 days per service recipient per year.~~

Personal Assistance shall mean the provision of direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, feeding/assistance with eating, meal preparation excluding cost of food, toileting and incontinence care, assistance with transfer and mobility), household chores essential to the health and safety of the person supported (e.g., washing dishes; personal laundry; general housecleaning in areas of the residence used by the service recipient); budget management, supervising and accompanying the person supported to medical appointments if needed, and on personal errands such as grocery shopping, picking up prescriptions, paying bills; and trips to the post office. It also may include medication administration as permitted under Tennessee's Nurse Practice Act. Personal Assistance shall be provided in accordance with therapeutic goals and objectives as specified in the plan of care.

Personal Assistance is a service that is provided for the direct benefit of the person supported. It is not a service that provides assistance to other members of the household (e.g., preparation of meals for the family, family laundry) who are not persons supported through the waiver. Personal Assistance staff shall not provide any personal assistance services to family members of the person supported, unless such family members are also supported through the waiver residing in the same home (e.g., when 2 siblings in the home are both waiver participants). When Personal Assistance is provided as a shared service for 2 or more family members who are waiver participants residing in the same home, the total number of units of shared Personal Assistance shall be apportioned based on an assessment of individual need and the apportioned amount included in the plan of care for each waiver participant, as applicable.

Personal Assistance is often delivered in the person supported place of residence; however, it may be provided outside the person supported home in community-based settings where the Personal Assistance provider accompanies the person supported to perform tasks and functions in accordance with the approved service definition and as specified in the plan of care. Personal Assistance does not include routine provision of Personal Assistance services in an area outside the person's ~~service recipient's~~ local community of residence. On an infrequent and exceptional basis and in accordance with the approved plan of care, Personal Assistance services may be provided in an area outside the person's ~~service recipient's~~ local community of residence.

Personal Assistance may be provided in the home or community; however, it shall not be provided in schools for school-age children, to replace personal assistance or similar services

required to be covered by schools, to transport or otherwise take children to or from school, or to replace services available through the Medicaid State Plan/TennCare Program. Personal Assistance services shall not be provided in the home of the Personal Assistant, except (1) when the service recipient lives in the home with the Personal Assistant or (2) on an infrequent and exceptional basis when the person supported is attending a special event (e.g., a party) that is held in the home of the Personal Assistant. Services provided in the Personal Assistant's home must be specified and in accordance with the approved ISP.

Personal Assistance may be provided during the day or night, as specified in the plan of care. A person supported who is receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive Personal Assistance.

Personal Assistant Services shall not be provided during the same time period that the person supported is receiving Day Services, Respite Services, services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof or as a substitute for education services which are available pursuant to IDEA, but which the person or his representative has elected to forego.

This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). Personal Assistance shall not be provided in a licensed facility (e.g., a group home, boarding home, or assisted living home) when the facility's licensure category requires the provision of personal assistance or personal care services.

Family members who provide Personal Assistance must meet the same standards as providers who are unrelated to the person supported. The Personal Assistant shall not be the spouse of a person supported and shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Personal Assistance provided by such individuals. Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order for Conservatorship.

Family members are required to implement services as specified in the individual support plan (ISP). Reimbursement to family members shall be limited to forty hours per week per family member for self-directed services as well as those delivered by contracted provider agencies. The person's Circle of Support is responsible for determining if the use of family members to deliver paid care is the best choice for the person supported and shall ensure that paid services do not supplant natural supports that would otherwise be provided at no cost to the Medicaid program ~~whether there is not an alternative provider to deliver the service~~.

The unit of reimbursement for Personal Assistance services shall be 15 minutes.

The Personal Assistance provider is not obligated to provide transportation for the person supported as part of the Personal Assistance service; however, a Personal Assistance provider who is also an Individual Transportation Services provider may bill for Individual Transportation Services for transport of the person supported into the community.

Personal Assistance may be provided out-of-state under the following circumstances:

a. Out-of-state services shall be for the purpose of visiting relatives or for vacations and shall be included in the person's plan of care. (Trips to casinos or other gambling establishments shall be excluded.)

b. Out-of-state services shall be subject to the same monthly limitation as Personal Assistance services provided in-state and in addition, are limited to a maximum of 14 days per person supported per waiver program year.

c. The waiver service provider agency must be able to assure the health and safety of the person supported during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state (i.e., provision of out-of-state services is at the discretion of the service provider).

d. During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the person supported and must ensure that staff meet waiver provider qualifications.

e. The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the person supported while receiving out-of-state services shall be the responsibility of the person supported and shall not be reimbursed through the waiver.

Semi-Independent Living Services (SILS) shall mean services that include training and assistance in managing money, preparing meals, shopping, personal appearance and hygiene, interpersonal and social skills building, and other activities needed to maintain and improve the capacity of an individual with an intellectual disability to live in the community.

The service also includes oversight and assistance in managing self-administered medication and/or medication administration as permitted under Tennessee's Nurse Practice Act.

This service is appropriate for people who need intermittent or limited support to remain in their own home and do not require staff that lives on-site. The person supported shall have the right to choose to live with others and share expenses or live alone. The person supported shall have the right to manage personal funds as specified in the Individual Support Plan.

Reimbursement for Semi-Independent Living Services shall not include the cost of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the person supported and other residents in the home (if applicable).

A person who is receiving Semi-Independent Living Services shall not be eligible to receive Personal Assistance, Respite or Transportation as separate services. With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program, transportation shall be a component of Semi-Independent Living Services and shall be included in the reimbursement rate for such.

The Semi-Independent Living Services provider shall not own the person's place of residence or be a co-signer of a lease on the person's place of residence unless the provider signs a written agreement with the person that states that the person will not be required to move if the primary reason is because the person desires to change to a different provider. The Semi-Independent Living provider shall not own, be owned by, or be affiliated with any entity that leases or rents a place of residence to a person supported if such entity requires, as a condition of renting or leasing, the person to move if the person desires to change to a different provider.

Semi-Independent Living Services shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for individuals with Intellectual Disabilities (ICFs/IID). Semi-Independent Living Services shall not be provided in a home where a person supported lives with family members unless such family members are also persons receiving Semi-Independent Living Services. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.

On a case-by-case basis, the DIDD Commissioner or designee may authorize Semi-Independent Living services for a person supported who resides with his or her spouse and or minor children.

Semi-Independent Living Services shall not be provided out-of-state.

A minimum of two face-to-face direct service visits per week are required for each person supported receiving Semi-Independent Living Services. However, providers delivering this service are required to implement provisions for 24/7 access to emergency supports.

Semi-Independent Living Services providers are required to be licensed as Mental Retardation (i.e., Intellectual Disabilities) Semi-Independent Living Facilities.

C-1 c.

All participants in the Self Determination Waiver Program will have a case manager (employed by ~~DIDS)~~ DIDD) assigned by ~~DIDS~~DIDD. Responsibilities include development of the initial interim plan of care; facilitating the development of the ISP/plan of care; ensuring that services are initiated within required timeframes; providing an orientation to self-determination; continuously reviewing the participant's budget; ongoing monitoring of the implementation of the plan of care; and submitting requests for alternative emergency back-up services.

Additionally, Transitional Case Management will be provided if needed, administratively rather than as a waiver service, for the purpose of community transition of a Medicaid eligible person residing in an Intermediate Care Facility for the ~~Mentally Retarded~~ Individuals with Intellectual Disabilities) (ICF/~~MR~~IID) or other institutional setting during the last 180 consecutive days of the person's institutional stay prior to being discharged and enrolled in the waiver. Transitional Case Management shall be person-centered and shall include, but not be limited to, ongoing assessment of the person's strengths and needs; development, evaluation, and revision of the transitional plan of care; assistance with the selection of service providers; provision of general education about the waiver program, including personal rights and responsibilities; and monitoring implementation of the transitional plan of care.

C-2: General Service Specifications

a. **Criminal History and/or Background Investigations.** Any staff person who has direct contact with or direct responsibility for the person supported must pass a criminal background check performed in accordance with a process approved by the ~~Division of Intellectual Disabilities Services~~ Department of Intellectual and Developmental Disabilities (DIDD) and must not be listed on the Tennessee Department of Health Abuse Registry, the Tennessee Sexual Offender Registry, the Tennessee Felony Offender List, or the Office of Inspector General Exclusion List.

A statewide criminal background check is performed by the Tennessee Bureau of Investigation or a Tennessee-licensed private investigation company. If the staff person has resided in Tennessee for one year or less, a nationwide criminal background check is required in accordance with ~~DIDS~~ DIDD requirements.

During Qualified Provider Reviews conducted by the ~~Division of Intellectual Disabilities Services~~ Department of Intellectual and Developmental Disabilities (DIDD), the provider's personnel files are reviewed to ensure that there is documentation that the mandatory background and registry checks have been conducted on potential staff who will have direct contact with or direct responsibility for the person supported.

b. Abuse registry screening
The state maintains the abuse registry:

A. Staff who have direct contact with or direct responsibility for the enrollee shall not be listed in the Tennessee Department of Health Abuse Registry, the Tennessee Sexual Offender Registry, r the Tennessee Felony Offender List, or the Office of Inspector General Exclusion List.

B. All service provider agencies, contractors and subcontractors must verify individual criminal history background information for employees and volunteers who provide direct care for, have direct contact with, or have direct responsibility for the safety and care of individuals enrolled in the Self-Determination Waiver Program.

ii. Larger Facilities:

The only services in this waiver that are provided in a residential setting are semi-independent living, respite and behavioral respite. Both services are provided on a temporary, short-term basis.

Some larger facilities, such as the ICF/~~MR~~IID campus, have "cottages" or "homes" as opposed to one large building. Some residential habilitation facilities have more than 4 beds, but many are 4 beds or less.

Living areas in larger facilities are personalized to provide a home-like atmosphere. Individuals decorate their own rooms and participate in decorating common living areas. Food may be prepared off campus and delivered at ICF/~~MR~~IID campus settings, or may be prepared on site with other facility types.

Individuals are afforded opportunities to participate in learning to cook, making snacks, setting the table, etc. based on each person's needs and preferences. Everyone has access to community resources and accesses those resources based on their needs and preferences as identified in their ISP.

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.

Family members who provide Personal Assistance, Respite, Individual Transportation Service or any other waiver service must meet the same standards as providers who are unrelated to the person supported and shall not be the spouse and shall not be the person supported parent or custodial grandparent if the person supported is a minor.

This requirement includes implementing services as specified in the individual support plan (ISP)/plan of care. Reimbursement to family members shall be limited to forty hours per week per family member, for self-directed services as well as those delivered by contracted provider agencies. The person's Circle of Support is responsible for determining if the use of family members to deliver paid care is the best choice for the person supported and shall ensure that paid services do not supplant natural supports that would otherwise be provided at no cost to the Medicaid program. ~~and whether there is not an alternative provider to deliver the service~~.

Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order of Conservatorship [T.C.A.1200-13-1-.25(3)l].

The state makes such allowances for the best interest of the recipient. In cases where payment to a family member allows the family to support the recipient in a more healthy and stable environment, payment to family members is allowable as stated above. Payment to family members is intended to promote a more healthy and stable residence and overall environment for the recipient, thus allowing them to stay in their own home. This promotes family involvement in the life of the recipient, with an intent to strengthen the enrollee's family unit.

Such service providers are also subject to review by both ~~DIDS~~DIDD and the State Medicaid Agency reviewers. Family members who are providers are expected to abide by all applicable state and federal guidelines, as well as all policies administered by either ~~DIDS~~DIDD or the State Medicaid Agency.

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.

Section (d) above addressed the question regarding legally responsible individuals including family members, receiving payment for provision of selected services. In Tennessee, "guardian" refers to the legally responsible person for a minor.

Family members who provide Personal Assistance, Respite, Individual Transportation Service or any other waiver service must meet the same standards as providers who are unrelated to the person supported and shall not be the spouse and shall not be the person supported parent or custodial grandparent if the person supported is a minor.

Reimbursement shall not be made to any other individual who is a conservator unless so permitted in the Order of Conservatorship [T.C.A. 1200-13-1.25(3)1].

f. Open Enrollment of Providers.

In addition to the provider qualifications specified in Appendix C-1 for each HCBS service, the following general requirements apply to all providers of waiver services:

• All providers shall be at least 18 years of age.

• Staff who have direct contact with or direct responsibility for the person supported shall be able to effectively read, write, and communicate verbally in English and shall be able to read and understand instructions, perform record-keeping, and write reports.

• Any waiver service provider who is responsible for transporting a person supported shall ensure that the driver has a valid driver’s license and current automobile liability insurance.

• Staff who have direct contact with or direct responsibility for the person supported shall pass a criminal background check performed in accordance with a process approved by the ~~Division of Intellectual Disabilities Services~~ Department of Intellectual and Developmental Disabilities.

• Staff who have direct contact with or direct responsibility for the person supported shall not be listed in the Tennessee Department of Health Abuse Registry, the Tennessee Sexual Offender Registry, the Tennessee Felony Offender List, or the Office of Inspector General Exclusion List.

• Waiver service providers shall not have been excluded from participation in the Medicare or Medicaid programs.

• All providers must comply with TennCare-approved policies, procedures, and rules for waiver service providers, including quality monitoring requirements.

QUALITY IMPROVEMENT: QUALIFIED PROVIDERS

a.

a.i.a.1. # & % of approved new providers who met all applicable qualifications (e.g. licensure/certification, background and registry checks, references) ~~applications for which the provider obtained applicable licensure/certification in accordance with state law and waiver provider qualifications~~ prior to service provision. % = # of newly approved providers ~~obtaining required licensure/certification~~ meeting all qualifications/ total # of newly approved providers ~~applications requiring licensure/certification~~.
~~a.i.a.2. # and % of new provider applications received for which appropriate criminal background, registry and reference checks were completed for identified executive staff prior to approval of the application. Percentage = number of applications documenting required background, registry, and reference checks / total number of applications approved.~~
a.i.a.11. # and % of newly employed (or reassigned) direct support staff ~~delivering services~~ who transport waiver participants and who had a current driver's license. Percentage = number of newly employed (or reassigned) direct support staff who transport waiver participants and had a current driver's license / total number of newly employed (or reassigned) direct support staff serving waiver participants in the QP sample.
~~a.i.a.12. Number and percent of DSS screened by the financial management agency (for participants who self direct) who passed a background check prior to, but no more than 30 days in advance of, employment. % = # of newly employed DSS serving participants who self direct with timely background checks / total number of newly employed DSS serving participants who self direct reviewed in the sample.~~
~~a.i.a.13. # and % of newly employed DSS screened by the financial management agency (for participants who self direct) with an Abuse Registry check prior to, but no more than 30 days in advance of, employment. % = # of newly employed DSS serving participants who self direct with timely Abuse Registry checks / total number of newly employed DSS serving participants who self direct in the sample.~~
~~a.i.a.14. # and % of newly employed DSS screened by the financial management agency with a Sexual Offender Registry check prior to, but no more than 30 days in advance of, employment. % = # of newly employed DSS serving participants who self direct with timely Sexual Offender Registry checks / total # of newly employed DSS serving participants who self direct in the sample.~~
~~a.i.a.15. # and % of newly employed DSS screened by the financial management agency (for participants who self direct) with a Tennessee Felony check prior to, but no more than 30 days in advance of, employment. % = # of newly employed DSS serving participants who self direct with timely Tennessee Felony checks / total number of newly employed DSS serving participants who self direct in the sample.~~

a. ii. Performance Measures a.i.a.4., a.i.a.5. through a.i.a.11, a.i.b.1, and a.i.c.1: Qualified Provider Reviews and Provider Performance Surveys are conducted annually for 100% of provider agencies who employ two (2) or more staff. Providers who achieve exceptional or proficient Provider Performance Survey scores, who achieve substantial compliance in Domain 3: Safety and Security, who have a substantiated rate of investigation which is less than 10 per 100, and who have no suspicious deaths since the previous provider performance survey qualify for reduction in the frequency (i.e., every two years) of the Provider Performance Survey. A representative sample of independent providers (e.g., physical therapists, occupational therapists, speech language pathologists, audiologists, nurses, nutritionists, and behavior service providers) who do not employ any additional staff (i.e., the provider consists of one person) will be surveyed/reviewed annually.

Performance Measure a.i.a.5.: Tennessee Code Annotated (33-2-1201) states: "Each organization shall have a criminal background check performed on each employee whose responsibilities include direct contact with or direct responsibility for persons supported."

~~Performance Measures a.i.c.1.: DIDS DIDD is in the process of transitioning from a "Train the Trainer" model (DIDS DIDD trains provider agency staff, who train staff employed by the agency) to a model which will utilize a web-based training system for completion of the majority of training required for direct support staff. Required supplemental training, such as Cardiopulmonary Resuscitation (CPR) and first aid, will still be completed utilizing resources external to the web-based system. Upon full implementation, DIDS DIDD and participating providers will have the option of tracking timely completion of external training programs utilizing the web-based system.~~

b. Methods for Remediation/Fixing Individual Problems

Performance Measures a.i.a.1. through a.i.a.3.: Providers who do not meet the requirements specified in these performance measures will not be allowed to sign a Provider Agreement, enroll in the ~~DIDS~~ DIDD and/or TennCare MMIS claims processing systems, or receive payment for services rendered. Applications that do not meet requirements will be denied. Written denials of provider applications will indicate which requirements have not been met and advise that the provider may reapply for consideration with additional documentation that such requirements have been met.

Performance Measure a.i.a.4.: When ~~DIDS~~ DIDD identifies that an existing provider has not maintained required licensure/certification, ~~DIDS~~ DIDD will notify TennCare within two (2) working days so that funds may be recouped for payment of any past period during which services were billed while the provider qualifications were not met. The Provider Agreement will be terminated unless proof of licensure/certification is submitted to ~~DIDS~~ DIDD within 30 days of the date the issue was identified. The provider will not be eligible for payment of claims until licensure/certification issues are resolved.

Performance Measures a.i.a.5. through a.i.a.8.: ~~DIDS~~ DIDD will review a sample of provider agency staff personnel records during Qualified Provider Reviews. A Qualified Provider Review will be conducted with the contracted fiscal management agency annually. For individual direct support staff who did not have required background/registry checks at the time of the Qualified Provider Review, ~~DIDS~~ DIDD will request that the background and/or registry check be initiated during the review. Designated ~~DIDS~~ DIDD Regional Office staff will be responsible for verifying that the background/registry check was obtained and reviewing the results. If staff did not pass the background/registry check, ~~DIDS~~ DIDD will require the provider agency or fiscal management agency to take appropriate personnel action(s), and designated ~~DIDS~~ DIDD Regional Office staff will verify that appropriate action was taken within 30 days of the provider's receipt of the completed background check.

For staff in the sample who commit a serious criminal offense during the course of employment, ~~DIDS~~ DIDD will determine if the provider agency or fiscal management agency took appropriate action, or if action is pending, will verify that action was taken within 30 days of discovery. Failure to obtain background or registry checks in accordance with state law and ~~DIDS~~ DIDD requirements and/or failure to take appropriate personnel actions may result in sanctions, including institution of a moratorium on serving new waiver participants.

Performance Measure a.i.a.9.through a.i.a.11: ~~DIDS~~ DIDD will review a sample of staff personnel records during Qualified Provider Reviews. For individual direct support staff who did not meet waiver general qualifications, ~~DIDS~~ DIDD will notify the provider or fiscal management agency and request that appropriate personnel action be taken, which may include termination of the employee, ensuring that the employee acquire the skills needed to meet general requirements, or reassignment to a non-contact position. Designated ~~DIDS~~ DIDD Regional Office staff will be responsible for verifying that the appropriate actions were taken within 30 days of discovery.

Performance Measure a.i.b.1.: Non-licensed/non certified providers who do not meet provider qualifications will be subject to termination of their Provider Agreement unless identified issues can be resolved within 30 days of the date of discovery. ~~DIDS~~ DIDD will notify TennCare within two (2) working days of any lapse in meeting provider qualifications, so that payment may be recouped for services reimbursed during the time period when qualifications were not met. The provider will not be able to receive reimbursement for additional services provided prior to the date when provider qualification issues are resolved.

Individual Remediation Data Aggregation: ~~DIDS~~ DIDD has developed a data flow document which identifies data collection, reporting, and aggregation tasks that must be completed to generate the required reports for submission to TennCare. For each task, due dates are specified. Responsible ~~DIDS~~ DIDD staff and back-up staff are identified for each task. Designated ~~DIDS~~ DIDD Central Office staff compile the data collected and entered by regional and central office staff into ~~DIDS~~ DIDD databases to create data files that are posted for TennCare analysis and aggregation. In addition, ~~DIDS~~ DIDD generates a Quality Management Report using the data collected and reported. The Quality Management Report is submitted to TennCare each month and information contained therein is reviewed during monthly State Quality Management Committee Meetings. ~~TennCare compiles monthly Compliance Summary Reports from DIDS DIDD data, which are also reviewed and analyzed during State Quality Management Meetings. Reports include information regarding the number of sample reviews completed, compliance percentages, individual remediation activities and timeframes required for remediation. Reports include cumulative totals for the waiver year to date. TennCare Compliance Summary Reports are distributed to DIDS DIDD management staff for discussion and analysis during monthly State Quality Management Committee Meetings.~~

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services.
The home and community-based service provided through this waiver are intended to provide services and supports that are essential for participants to continue residing in their own or family homes and participate as members of their communities. The services are classified under two broad service categories: (a) the Supports for Community Living Service Category and (b) the Professional and Technical Supports Service Category. The cost of home and community-based services provided under this waiver is limited to $30,000 per year per participant except as described herein. In limited circumstances, supplemental Emergency Assistance may be provided to a participant when the cost of services provided under the two broad service categories has reached the $30,000 limit. The total budget for all waiver services, including Emergency Assistance, shall not exceed $36,000 per year per individual.

The Supports for Community Living Service Category includes the following services: Behavioral Respite Services, Respite, Personal Assistance, Day Services, Semi-Independent Living Services, and Individual Transportation Services. A participant's use of any service or combination of services included in the Supports for Community Living Service Category is limited to $23,000 per year per participant unless an exception to the service limit has been approved.

The Professional and Technical Supports Service Category includes the following services: Occupational Therapy; Physical Therapy; Speech, Language and Hearing; Nursing; Specialized Medical Equipment and Supplies and Assistive Technology; Behavior Services; ~~Vehicle Accessibility Modifications~~; Environmental Accessibility Modifications; Personal Emergency Response System; Orientation and Mobility Services for Impaired Vision; Nutrition Services, and Adult Dental Services. A participant's use of any service or combination of services included in the Professional and Technical Supports Service Category is limited to $7,000 per year per participant unless an exception to the service limit has been approved.

An exception to the service limit in either category may be approved if the increased service limit is determined necessary to protect the participant's health and welfare, prevent the participant's admission to an institution or an exception is necessary to ensure that the participant receives services necessary to achieve goals identified in the ISP. In the event an exception to a service category limit is approved, the combination of services included in the Supports for Community Living Service Category and the Professional and Technical Supports Service Category may not exceed $30,000 per participant per year.

Supplemental emergency assistance services may be provided in an amount not to exceed $6,000 when: (a) the total cost of services or combination of services included in Supports for Community Living and the Professional and Technical Supports Service Categories totals $30,000 and (b) the participant has experienced the following:

•Permanent or temporary involuntary loss of the participant's current residence for any reason;

•Loss of the current caregiver for any reason, including death of a caregiver or changes in the caregiver's mental or physical status resulting in the caregiver's inability to perform effectively for the individual;

•Significant changes in the behavioral, physical or mental condition of the individual that necessitates increased services.

Emergency Assistance consists of services available in the Supports for Community Living Category and the Professional and Technical Supports Service Category.

In addition, selected services have service limits as specified in Appendix C-1/C-3. Limits on Sets of Services are discussed during a person's original orientation to the Self-Determination Waiver.

Prospective Individual Budget Amount
The individual cost limit is $30,000 per program year per individual. The $30,000 limit provides for up to $23,000 per year per individual in the Supports for Community Living Category, and $7,000 per year per individual in the Professional and Technical Support Services Category. Exceptions may be granted to increase the $23,000 or $7,000 limit so long as the $30,000 combined limit is not exceeded.

When an individual's budget reaches $30,000, emergency assistance services may be provided to the person in an amount up to $6,000 (as described above) in order to provide an extra measure of protection when the person experiences a crisis or emergency situation that threatens his/her health and well-being.

The total of all waiver services shall not exceed $36,000 per year per participant.

~~This limit provides a wide array of services, excluding residential services, that enable participants, especially children, to get off the state waiver waiting list. To do so efficiently, the budgetary impact and the number of service recipients taken off the waiver was estimated and determined to be appropriate for that purpose.~~

Should this waiver no longer meet the needs of the individual due to an increase in need, provisions exist for the individual to transition to other state HCBS waivers as appropriate.

Limits on the Individual budget amount are discussed during a service recipient's original orientation to the Self-Determination Waiver.

APPENDIX D: PARTICIPANT-CENTERED PLANNING AND SERVICE DELIVERY
D-1: SERVICE PLAN DEVELOPMENT

a. Responsibility for Service Plan Development.

In addition to general qualifications applicable to all providers, individuals employed as case managers must meet the following educational/professional experience requirements:

1. A Bachelor's degree from an accredited college or university in a human services field;

2. A Bachelor's degree from an accredited college or university in a non-related field and one (1) year of relevant experience;

3. An Associate degree plus two (2) years of relevant experience; or

4. Four (4) years of relevant experience. (Relevant experience means experience in working directly with persons with intellectual, developmental, or other types of disabilities or mental illness.) Since the case managers are state employees, the ~~DIDS~~ DIDD Regional Office is responsible for the determination that the case manager meets the minimum qualifications. The determination is documented in the case manager's personnel records which must specify that prior work experience meets the minimum job qualifications.

Case Managers who do not have a Bachelor's degree in a human services field must be supervised by someone who does meet that qualification. Case Managers must successfully complete required pre-service training courses as well as periodic in-service trainings and any other re-training required to maintain approval to be a case manager.

c. Supporting the Participant in Service Plan Development

Case Manager Role in Self-Determination

All participants have an assigned ~~DIDS~~ DIDD case manager who has the following responsibilities:

- To conduct a comprehensive assessment of the person's needs, including an assessment of the natural supports that are available to meet such needs;
- To develop the initial interim plan of care;
- To facilitate the development of the participant's ISP/plan of care, including arranging for a person-centered planning facilitator if desired by the participant;
- To ensure that services are initiated within required time frames;
- To help coordinate access to covered physical and behavioral health services;
- To provide an orientation to self-direction so that the participant has the information necessary to understand the requirements and responsibilities associated with self-direction;
- To inform participants who elect self-direction of the Financial Administration/Supports Brokerage entity or entities;
- To continuously review the status of the participant's self-determination budget;
- To conduct ongoing monitoring of the implementation of the ISP/plan of care and participant health and welfare; and,
- To arrange alternative emergency back-up services as necessary in the event that the emergency back-up services provided for in the ISP/plan of care cannot be employed.

Supports Brokerage

The state provides supports brokerage as an administrative service for individuals choosing to self-direct. These services are accessed through the administrative contract ~~DIDS~~ DIDD has with the financial management services entity.

One of the ~~essential services provided~~ functions performed by the supports broker is independent advocacy for participants who have elected to self-direct some or all of their services. Supports brokerage is designed to assist the enrollee in locating, accessing, and coordinating needed services. A supports broker serves as a link between the participant or the participant's guardian or conservator, providers and the financial management services entity. Authority and responsibility for self-direction is retained by the participant or the participant's guardian or conservator.

A participant or the participant's guardian or conservator who elects self-direction works with the DIDD contracted supports broker to provide the following assistance in managing participant managed services:

- To provide training to the participant in participant managed services;
- To assist the participant in the recruitment of individual providers of participant managed services and negotiating payment rates;
- To assist the participant in the scheduling, training, and supervision of individual providers;
- To assist in the development of a back-up plan;
- To assist the participant in the managing and monitoring of the individual budget; and,
- To assist the participant in monitoring and evaluating the performance of individual providers.

A supports broker also may assist in locating and securing services, supports (including informal, unpaid supports) and other community resources that promote community integration, community membership and independence, as provided in the ISP/plan of care. As requested by the enrollee or the enrollee's guardian or conservator, the supports broker also may participate in the development of the ISP/plan of care. A supports broker shall collaborate with but not duplicate the functions of the ~~DIDS~~ DIDD regional office case manager.

Transitional Case Management

Transitional Case Management is provided, if needed, administratively rather than as a waiver service, for the purpose of community transition of a Medicaid eligible person residing in an Intermediate Care Facility for the ~~Mentally Retarded~~ Individuals with Intellectual Disabilities (ICF/~~MR~~ IID) or other institution during the last 180 consecutive days of the person's institutional stay prior to being discharged and enrolled in the waiver. Transitional Case Management is person-centered and includes, but is not limited to, ongoing assessment of the enrollee's strengths and needs; development, evaluation, and revision of the transitional plan of care; assistance with the selection of service providers; provision of general education about the waiver program, including enrollee rights and responsibilities; and monitoring implementation of the transitional plan of care.

Intake Staff

Part of the initial screening process by ~~DIDS~~DIDD Intake staff is to advise and explain to the individual or family representative acting on behalf of the individual, the operation of the waiver program and waiver services offered as an alternative to care in an Intermediate Care Facility for individuals with ~~Mental Retardation~~ Individuals with Intellectual Disabilities (ICF/~~MR~~IID).

The intake staff reviews the Pre-Admission Evaluation and the plan of care, provides a list of available service providers with contact information, and answers any questions related to the waiver. The intake staff person provides information, including a copy of the Family Resource Guide, to the enrollee or enrollee's family representative. The Family Resource Guide is a guide available to support services for family members of individuals with ~~mental retardation~~ intellectual disabilities.

d. Service Plan Development Process.

~~DIDS~~DIDD case managers assist individuals in identifying their needs and preferences, and selecting, obtaining and coordinating services using paid and natural supports. The ~~DIDS~~DIDD case manager, in collaboration with the participant, the participant's authorized representative (if applicable), other persons invited by the participant, and service providers convene in a formal Planning Meeting to discuss and finalize the plan of care which is the Individual Support Plan (ISP). Prior to the development of the initial Individual Support Plan (ISP), waiver services are provided in accordance with the initial plan of care included in the approved ICF/~~MR~~IID Pre-Admission Evaluation. The time period for development of the ISP after enrollment into the HCBS waiver is 60 calendar days.

The policy and procedures which define and guide the family or person-centered planning process and assure that families are integrally involved in the development of a plan of care that reflects their preferences, choices, and desired outcomes include:

a. An assessment of the individual's status, adaptive functioning, and service needs through the administration of the uniform assessment (e.g. Inventory for Client and Agency Planning {ICAP} or Supports Intensity Scale {SIS}) instrument;

b. The identification of individual risk factors through the administration of the Risk Issues Factor Identification Tool;

c. Additional assessments, where appropriate, by health care professionals (e.g., occupational or physical therapists, behavior analysts, psychiatrists);

d. An orientation of the participant to self-direction which provides basic information about self-direction, including the benefits and participant responsibilities. When the participant expresses an interest in participant directed services , a follow-up meeting will be held prior to the formal Planning Meeting and the case manager will ensure that the services to be participant-managed are identified in the ISP, as well as name of the vendor providing the Financial Administration/ Supports Brokerage service;

e. The identification of personal outcomes, support goals, supports and services needed, information about the individual's current situation, what is important to the individual, and changes desired in the person's life (e.g., home, work, relationships, community membership, health and wellness). (Information for the ISP will be gathered and developed in collaboration with the individual and the individual's guardian or conservator, as well as family members and other persons who the individual wants to be involved.); and

f. A formal Planning Meeting which is convened to finalize the ISP.

The plan of care is the fundamental tool by which the state will ensure the health and welfare of the individuals served under this waiver. As such, it is subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability, and responsive to the individual's needs and preferences. Ongoing monitoring by the ~~DIDS~~ DIDD case manager is accomplished through quarterly face-to-face monitoring visits and completion of a monthly status review of the plan of care.

The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service regardless of funding source.

e. Risk Assessment and Mitigation.

A Risk Issues Identification Tool is administered as part of the process for developing the person's ISP. A person-centered approach is employed to identify risk factors and develop proactive strategies to address those factors. The tool identifies potential situational, environmental, behavioral, medical, and financial risks. When risks are identified, the action steps necessary to address them are incorporated into the ISP.

The DIDD has a system in place for assuring emergency back-up and/or emergency response capability in the event those providers of services and supports essential to the individual's health and welfare are not available. While the state may define and plan for emergencies on an individual basis, the state also must have system procedures in place.

As a result of the administration of the Risk Issues Identification Tool, situations will be identified when access to emergency back-up services could be required and appropriate person-centered strategies will delineate how emergency back-up services will be triggered and responsibilities for ensuring that such services are furnished. As appropriate, strategies will identify informal (unpaid) supports that could assist in meeting emergency back-up needs.

If emergency back-up strategies that have been included in the ISP cannot be implemented, the ~~DIDS~~ DIDD case manager will arrange alternate emergency back-up services through the region's provider network. . As a third tier of emergency back-up services, regional office personnel or staff from a state Developmental Center will directly furnish the emergency back-up services.

The state has procedures for how it will work with families and their employer agents (if applicable) to monitor the ongoing expenditures of the individual budgets.

The financial management services ~~Administration~~ entity is required to prepare a monthly report that details participant expenditures for participant-managed services. These monthly reports will be distributed to the participant, and the ~~DIDS~~ DIDD regional office case manager. In addition, the Financial Administration/Supports Brokerage entity is required to alert the ~~DIDS~~ DIDD regional office whenever the pattern of expenditures reveals the potential that the self-determination budget would be prematurely exhausted. The ~~DIDS~~ DIDD case manager will review the monthly expenditure report to identify potential problems, including potential over-expenditure of funds or expenditure patterns that might indicate that the participant is having difficulty in accessing authorized services. The ~~DIDS~~ DIDD case manager will follow-up with the participant and/or the Financial Administration/Supports Brokerage entity (if applicable).

The state has procedures for how it will handle those instances where this ongoing monitoring has failed to prevent the expenditure of the individual budget in advance of the re-determination date. These procedures are to assure that services needed to avoid out-of-home placement and the health and welfare of the individual are available.

There will be close, continuous monitoring of the funds contained in the self-determination budget by the Financial Administration/Supports Brokerage entity, and the ~~DIDS~~ DIDD case manager. All disbursements of funds must be approved by the participant and will be made only upon the presentation of proper documentation and the determination by the Financial Administration/Supports Brokerage entity that the disbursement would be made for items identified in the approved ISP. The Financial Administration/Supports Brokerage entity will alert the case manager to potential overspending.

f. Informed Choice of Providers.

Participation in a waiver program is voluntary. Prior to being enrolled in a waiver, a qualified applicant has the right to freely choose whether they want to receive services in the waiver or in an Intermediate Care Facility for the ~~Mentally Retarded~~ Individuals with Intellectual Disabilities (ICF/~~MR~~IID). Freedom of choice also includes the right to select any provider with an active provider agreement with the ~~Division of Intellectual Disabilities Services~~ Department of Intellectual and Developmental Disabilities (DIDD) and the Bureau of TennCare; if the provider is available, willing, and able to provide the services needed.

The state assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care. The ~~DIDS~~DIDD case manager will provide information about selecting from among qualified providers of the waiver services in the service plan. For self-directed services, the Supports Broker will assist the participant in the recruitment of providers of participant-managed services and negotiating payment rates.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.

The Individual Support Plan (ISP), which is the individualized plan of care, and any subsequent amendments to it are reviewed and approved by the ~~Division of Intellectual Disabilities Services (DIDS)~~Department of Intellectual and Developmental Disabilities (DIDD) and are subject to the approval of the Bureau of TennCare, the State Medicaid Agency.

D-2: Service Plan Implementation and Monitoring
a. Service Plan Implementation and Monitoring.

Case Managers assist service recipients in identifying needs and preferences, and in selecting, obtaining, and coordinating services using paid and natural supports. Ongoing monitoring by Case Managers is essential since they are closest to the service recipient and are in the best position to determine if services are being implemented as specified in the ISP/plan of care and if the services described in the plan are meeting the service recipient's needs. Monitoring by Case Managers is accomplished through completing a minimum of one face-to-face visit each quarter (or more frequently as needed) across all service delivery environments and by completing a Monthly Status Review of the ISP/plan of care. The frequency of case manager monitoring visits shall be specified in the ISP/plan of care. Information is gathered using standardized processes and tools.

The Case Manager reports issues identified to management staff from the appropriate provider agencies. ~~DIDS~~DIDD Regional Office management staff may assist in achieving resolution when timely provider response does not occur.

All individuals who receive supports and services through ~~DIDS~~DIDD are required to have an annual risk assessment. This assessment is a component of the planning process intended to identify potential risks and create an environment that establishes appropriate safeguards without limiting personal experiences. Risk management is accomplished through risk assessment and identification of risk factors, risk analysis and planning, ongoing evaluation of the effectiveness of risk management strategies, and staff training and re-training as appropriate.

The success of individual strategies to ameliorate individual risks identified through risk assessment are evaluated by the service recipient, their families and significant others, providers, and the Support Coordinator as part of on-going planning for and monitoring of services.

QUALITY IMPROVEMENT: SERVICE PLAN

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

~~a.i.a.1. Number and percentage of waiver participants who have Individual Support Plans with functional outcomes. Percentage = number of waiver participants who have ISPs with functional outcomes / total number of waiver participants in the sample.~~
a.i.a.2. Number and percentage of waiver participants who have Individual Support Plans with measurable action steps applicable to each of the outcomes specified. Percentage = number of waiver participants who have ISPs with measurable action steps for each outcome/ total number of waiver participants in the sample.
~~a.i.a.3. Number and Percentage of waiver participants who have Individual Support Plans with action steps that are written in measurable terms. Percentage = number of waiver participants who have ISPs with measurable action steps / total number of waiver participants in the sample.~~

b.

~~a.i.b.4. Number and percentage of waiver participants whose Individual Support Plans identify which services they intend to self-direct. Percentage = Number of waiver participants whose Individual Support Plans correctly identify self-directed services / total number of waiver participants in the sample who self- direct.~~
~~a.i.b.8. Number and percentage of waiver participants whose Individual Support Plans accurately reflect the current amount, frequency, and duration of waiver services received. Percentage = number of participants whose ISPs accurately reflect the current amount, frequency, and duration of waiver services / total number of waiver participants in the sample.~~

b.ii. Performance Measures a.i.a.1. through a.i.a.3., a.i.b.1. through a.i.b.9, a.i.c.1. and a.i.c.2., a.i.d.1. through a.i.d.4., and a.i.e.1. through a.i.e.6.: A representative sample of waiver participants will be generated at the beginning of the waiver year. The sample will be divided as evenly as possible to collect data during the following twelve (12) months. For each waiver participant included in the sample, Individual Record Reviews will be conducted by designated ~~DIDS~~ DIDD Regional Office staff. Staff will review waiver participant records, including claims data, to obtain the information needed to determine compliance with these performance measures.

Performance Measures a.i.a.4.: Data will be collected during ~~DIDS~~ DIDD participant satisfaction surveys (People Talking to People). Survey interviewers are trained prior to conducting surveys regarding ~~DIDS~~ DIDD policies and procedures for identifying and reporting complaints and incidences of abuse, neglect, and exploitation.

b. Methods for Remediation/Fixing Individual Problems

Performance Measures a.i.a.1. through a.i.a.3., a.i.b.1. through a.i.b.9., a.i.c.1. and a.i.c.2., and a.i.e.1. through a.i.e.6.: Designated ~~DIDS~~ DIDD Regional Office staff will notify Support Coordination Agencies and other provider agencies as appropriate when service planning and implementation compliance issues are identified. Regional Office staff will monitor remediation actions until able to verify that the issue has been resolved satisfactorily.

Remediation actions and timeframes are reported to TennCare monthly. TennCare notifies ~~DIDS~~ DIDD of any remediation determined unacceptable and requires ~~DIDS~~ DIDD to provide additional information and/or take additional remedial action until remediation can be determined appropriately completed.

Support Coordination agencies will be held accountable for ensuring necessary corrections are made to Individual Support Plans, for taking appropriate personnel actions, and for reporting remedial actions and resolution dates to ~~DIDS~~ DIDD Regional Office staff. Other contracted providers will be held accountable, as appropriate, for resolution of issues involving ISP/plan of care implementation. Remediation actions are expected to be completed within a targeted time frame of 30 days.

Performance Measure a.i.a.4.: When individuals report issues with the ISP/plan of care, the satisfaction survey interviewer will notify the ~~DIDS~~ DIDD People Talking to People Director within three working days. The ~~DIDS~~ DIDD People Talking to People Director will take appropriate action, which could include filing a complaint if appropriate and in accordance with the waiver participant's wishes, or notifying the Support Coordinator of the waiver participant's need to consider plan amendment. The ~~DIDS~~ DIDD People Talking to People Director will monitor remedial actions and track remediation timeframes. Complaints filed will be resolved in accordance with ~~DIDS~~ DIDD complaint resolution processes. ~~DIDS~~' DIDD goal is to resolve complaint issues within a 30 day time frame. Designated ~~DIDS~~ DIDD staff will compile monthly information about complaints and complaint resolution, including complaint types and referral sources, into data files and the Quality Management Report, all of which will be submitted monthly to TennCare. Appeals filed will be processed in accordance with TennCare rules and TennCare approved ~~DIDS~~ DIDD policy.

APPENDIX E: PARTICIPANT DIRECTION OF SERVICES

E-1: Overview
a. Description of Participant Direction.

The Self-Determination Waiver Program provides that certain services may be managed directly by the participant. The participant or the conservator or family (as appropriate) will decide whether to directly manage these services or receive them through the standard service delivery method. When a participant or the conservator or family elects to manage one of more services included in the ISP/plan of care, a Financial Administration/Supports Brokerage entity will assist in their management of the self-determination budget and other facets of self-direction.

The participant's self-determination budget will include the services in the ISP/plan of care that the participant has elected to manage directly. The participant will have the flexibility in managing the self-determination budget.

1. Participant Role Under Self-Direction:

In the case of minor children, the decision to elect to self-direct will be made by the child's legally responsible family member or guardian. In the case of adults, the decision to elect to self-direct will be made by the participant except when the participant has a legally-appointed representative. In addition, an adult participant who does not have a legally-appointed representative may designate one or more individuals (including family members, friends, or other persons) to advise and assist the participant in self-directing his/her services.

Such a representative must meet the following requirements:

- Demonstrate knowledge and understanding of the participant's needs and preferences;
- Be willing to comply with program requirements;
- Be at least 18 years of age;
- Be approved by the participant to act in this capacity; and,
- Not be a provider of services under this program.

When a representative has been designated, the representative will act on the participant's behalf in conducting activities related to self-direction.

The participant's key responsibilities when self-direction is selected are:

- Lead the ISP development process;
- Receive an orientation to and training in self-determination/self-direction from the Financial Administration/Supports Brokerage entity;
- Understand the rights and responsibilities of directing one's care and be willing to manage services or select a representative who is willing and capable of assuming this responsibility;
- Develop a back-up/emergency plan that is included in the ISP;
- Recruit, hire, and manage personal assistants and other providers of participant-managed services;
- Prepare an outline of duties and work schedule for providers of participant-managed services;
- Notify providers of participant-managed services of schedule changes in a timely manner;
- Train and evaluate providers of participant-managed services as necessary;
- Negotiate reimbursement or payment rates approved by the state with providers of participant-managed services;
- Serve as the employer of record for providers of participant-managed services;
- Verify accuracy of documentation or provide documentation, as appropriate, to the Financial Administration entity regarding services provided;
- Review and monitor payments for services reported by the Financial Administration entity to confirm that services have been rendered;
- Notify the case manager and Financial Administration/Supports Brokerage entity (if applicable) of concerns about service delivery that affect health and welfare; and
- Develop and manage services within the self-determination budget;

2. Supports Brokerage Activities

Supports brokerage is an activity provided by the Financial Administration/Supports Brokerage entity which assists a participant by:

- Providing training to the participant concerning self-determination/self-direction;
- Assisting the participant in the recruitment of providers of participant-managed services and negotiating payment rates;
- Assisting the participant in the scheduling, training and supervision of providers of participant-managed services;
- Assisting the participant in developing a back-up plan;
- Assisting the participant in managing and monitoring the self-determination budget;
- Assisting the participant in monitoring and evaluating the performance of providers of participant-managed services;

- Maintaining contact with the participant to ensure that needed services are being provided;
- Participation in the development of the ISP/plan of care if requested by participant; and
- Notifying the participant's case manager in the event of concerns about service delivery problems or issues that affect health and welfare.

3. Case Manager Role in Self-Determination

All participants will have an assigned ~~DIDS~~ DIDD case manager. The case manager will have the following responsibilities:

- Develop the initial, interim plan of care;
- Facilitate the development of the participant's ISP/plan of care, including arranging for a person-centered planning facilitator if desired by the participant;
- To ensure that services are initiated within required time frames;
- Provide an orientation to self-direction so that the participant has the information necessary to understand the requirements and responsibilities associated with self-direction;
- Inform participants who elect self-direction of the required use of the DIDD contracted Financial Management Services/Supports Brokerage entity or entities; ~~Inform participants who elect self-direction of the Financial Administration/Supports Brokerage entity or entities;~~
- Continuously review the status of the participant's self-determination budget;
- Conduct ongoing monitoring of the implementation of the ISP/plan of care and participant health and welfare; and,
- Arrange alternative emergency back-up services as necessary in the event that the emergency back-up services provided for in the ISP/plan of care cannot be employed.

4. Financial Administration Activities:

A participant must utilize a Financial Management Services ~~Administration~~/Supports Brokerage entity when self-direction is selected. Financial Administration activities focus on the financial, ministerial and clerical aspects associated with hiring or employment of individuals by the participant or the participant's guardian/conservator and making payment for participant-managed services.

Financial Management Services ~~Administration activities~~ include:

Providing the individual or the individual's guardian/conservator with the information and materials required for them to carry out self-direction and participant service management including procedures for approving payment for services and obtaining necessary payroll and employment information;

- Filing claims with ~~DIDS~~ DIDD for payment through the MMIS;
- Reimbursing providers of participant-managed services (i.e., processing payroll);
- Assuring that funds are disbursed only for services that are authorized in the ISP, approved by the participant, and properly documented.
- Preparing and submitting a monthly, self-determination budget status report to the participant, and the ~~DIDS~~ DIDD regional office case manager;
- Making payroll deductions (including applicable taxes); and,

- Verification that providers of participant-managed services possess the qualifications specified and, as necessary, arranging for the criminal background checks at no cost to the participant.

The following waiver services may be managed directly by the participant:
1. Respite Services (when provided by an approved respite provider who serves only 1 participant;
2. Personal Assistance;
3. Day Services (except facility-based); and
4. Individual Transportation Services.

d. **Election of Participant Direction.**

The following waiver services may be managed directly by the participant:

1. Respite Services when provided by an approved Respite provider who serves only 1 participant;
2. Personal Assistance;
3. Day Services except facility-based Day Services; and
4. Individual Transportation Services.

e. **Information Furnished to Participant.**

All waiver eligible individuals are informed of the variety of service options available to them. The state has procedures to assure that families and individuals requesting services have the requisite information and/or tools to participate in a family or person-centered planning approach and to direct and manage their care as outlined in the individual plan of care. All participants will have a ~~DIDS~~ DIDD case manager who will develop the initial interim plan of care, facilitate the development of the participant's individual Support Plan (ISP)/plan of care, and provide an orientation to self-determination/self-direction. During the development of the Individual Support Plan the ~~DIDS~~ DIDD case manager will provide participants and families with an orientation to self-direction, including information concerning the added responsibilities and benefits of self-direction. The state will make available and provide services such as assistance in locating and selecting qualified workers, training in managing workers, completing and submitting paperwork associated with billing, payment and taxation.

f. Participant Direction by a Representative.

The participant-appointed representative must be willing to accept responsibility for self-directing services on behalf of the participant and must:

- Understand the rights and responsibilities of directing the participant's care and be willing to manage services;
- Develop a back-up/emergency plan that is included in the ISP;
- Recruit, hire, and manage personal assistants and other providers of participant-managed services;
- Prepare an outline of duties and work schedule for providers of participant-managed services;
- Notify providers of participant-managed services of schedule changes in a timely manner;
- Train and evaluate providers of participant-managed services as necessary;
- Negotiate reimbursement or payment rates with providers of participant-managed services;

- Serve as the employer of record for providers of participant-managed services;
- Verify accuracy of documentation or provide documentation, as appropriate, to the Financial Administration entity regarding services provided;
- Review and monitor payments for services reported by the Financial Administration entity to confirm that services have been rendered;
- Notify the case manager and Financial Administration/Supports Brokerage entity (if applicable) of concerns about service delivery that affect health and welfare; and
- Develop and manage services within the self-determination budget.

If the participant's representative is unwilling or unable to carry out the responsibilities outlined above, ~~DIDS~~ DIDD may require the participant to select another personal representative or may require the participant to only use agency based services.

The participant's right to self-direct will be terminated if the participant's appointed representative refuses to abide by the ISP or related waiver policies, resulting in the inability to assure quality care or the health and safety of the person, and the participant will not select an alternate representative.

i. Provision of Financial Management Services.
i. Types of Entities:

The State provides Financial Administration services as an administrative cost through a contract with a financial management services company. The contract was awarded through the State's competitive bidding process for awarding contracts. The procurement method resulted in the selection of a single entity to furnish financial management services.

iii. Scope of FMS.
Other:
-Filing claims through ~~DIDS~~ DIDD to the MMIS for participant managed services and reimbursing individual providers

- Making Workers Compensation premium payments for persons employed by participants (if applicable according to state law)

-Verifying that goods and services for which reimbursement is requested have been authorized in the ISP/plan of care;

-Ensuring that requests for payment have been approved by the participant or the participant's guardian or conservator.

iv. Oversight of FMS Entities.

On an annual basis, the Office of Quality Management ~~Internal Audit section~~ of the ~~Division of Intellectual Disabilities Services (DIDS)~~ Department of Intellectual and Developmental Disabilities (DIDD) conducts a performance audit of the contractor that provides financial management services for participants in the Self-Determination Waiver. The auditors review a sample of participants for whom the contractor provides financial management services to support participant-managed services. If deficiencies are identified during the audits, the contractor will be required to submit an acceptable corrective action plan that addresses the deficiencies.

j. Information and Assistance in Support of Participant Direction.

Case Manager Role in Self-Direction

All participants have an assigned ~~DIDS~~ DIDD case manager. ~~DIDS~~ DIDD regional office case managers contact each participant and review the ISP/Plan of Care (POC) no less frequently than once a month and conduct a face-to-face interview at least quarterly.

The case manager has the following responsibilities:

• To develop the initial, interim plan of care;

• To facilitate the development of the participant's POC, including arranging for a person-centered planning facilitator if desired by the participant;

• To ensure that services are initiated within required time frames;

• To provide an orientation to self-determination so that the participant has the information necessary to understand the requirements and responsibilities associated with self-determination;

• To continuously review the status of the participant's self-determination budget;

• To conduct ongoing monitoring of the implementation of the POC and participant health and welfare; and

• To arrange alternative emergency back-up services as necessary in the event that the emergency back-up services provided for in the POC cannot be employed.

Administrative Activity

The role of the ~~DIDS~~ DIDD case manager was described above. ~~DIDS~~ DIDD contracts with a financial management services company to provide financial management support for self-direction and to provide supports brokerage services.
~~, the latter of which is subcontracted through a major advocacy organization. The contract was awarded through the State's competitive bidding process for awarding contracts. Reimbursement to the contractor is made on a per person per month basis.~~

The financial management services provider has the responsibility for the following financial management support services:

1. Providing the participant or the participant's guardian/conservator with the information and materials necessary to self-direct services, including procedures for approving payment for services and obtaining necessary payroll and employment information;
2. Filing claims with ~~DIDS~~ DIDD for payment;
3. Reimbursing providers of participant-managed services;
4. Assuring that funds are disbursed only for services that are authorized in the ISP (plan of care) approved by the participant and that are properly documented.
5. Preparing and submitting a monthly self-determination budget status report to the participant and the ~~DIDS~~ DIDD regional office case manager;
6. Making payroll deductions; and
7. Verification that providers of participant-managed services possess required qualifications.

~~Though its subcontract with an advocacy organization~~ The financial management services contractor provides supports brokerage services to enable the participant to self-direct participant-managed service and is responsible for the following supports brokerage services:

1. Providing training to the participant in participant managed services;
2. Assisting the participant in the recruitment of individual providers of participant managed services and negotiating payment rates;
3. Assisting the participant in the scheduling, training, and supervision of individual providers;
4. Assisting the participant in the managing and monitoring of the individual budget;
5. Assisting the participant in monitoring and evaluating the performance of individual providers; and
6. Notifying the participant's case manager in the event of concerns about service delivery problems or issues that affect health and welfare.

A supports broker also may assist in locating and securing services and other community resources that promote community integration, community membership and independence, as provided in the ISP (plan of care). As requested by the participant or the participant's guardian or conservator, the supports broker also may participate in the development of the ISP.

On an annual basis, the ~~Internal Audit section~~ Office of Quality Management of the ~~Division of Intellectual Disabilities Services~~ (~~DIDS~~ Department of Intellectual and Developmental Disabilities (DIDD) ~~- the Operating Agency~~) performs an audit of the contractor that provides financial management services and supports brokerage services. During on-site surveys, the auditors assess contract compliance to ensure that the contractor is performing contracted waiver administrative functions to support participant-managed services and that such activities are carried out in accordance with waiver requirements and the terms and conditions of the contract with ~~DIDS~~ DIDD. If deficiencies are identified during the audits, the contractor will be required to submit an acceptable corrective action plan that addresses the deficiencies.

The state provides supports brokerage as an administrative service rather than as a waiver service. The ~~Division of Intellectual Disabilities Services~~ Department of Intellectual and Developmental Disabilities (DIDD) contracts with a financial management services company to provide both financial management services and supports brokerage services for participants who choose to self-direct waiver services.
~~The financial management services company subcontracts with a major non-profit statewide advocacy organization on intellectual and developmental disabilities to provide supports brokerage services which include independent advocacy services.~~

~~Included in the services provided by the supports brokerage agency is independent advocacy.~~
Supports brokerage is an activity designed to enable a participant to manage services and to assist the enrollee in locating, assessing, and coordinating needed services. A supports broker serves as a link between the participant or the participant's guardian or conservator, providers and the financial administration entity. Authority and responsibility for self-direction is retained by the participant or the participant's guardian or conservator.

~~**k. Independent Advocacy**~~

~~A participant or the participant's guardian or conservator who elects self-determination may select a supports broker/advocate to provide the following assistance in managing self-directed services:~~

~~-Providing training to the participant concerning self-direction of services;~~

~~-Assisting the participant in the recruitment of individual providers of participant managed services and negotiating payment rates;~~

~~-Assisting the participant in the scheduling, training, and supervision of providers of self-directed services;~~

~~-Assisting the participant in the managing and monitoring of the individual budget;~~

~~-Assisting the participant in monitoring and evaluating the performance of providers of self-directed services;~~

~~-Maintaining contact with the participant to ensure that needed services are being provided;~~

~~-Participation in the development of the Individual Support Plan (plan of care) if requested by participant; and~~

~~-Notifying the participant's case manager in the event of concerns about service delivery problems or issues that affect health and welfare.~~

l. Voluntary Termination of Participant Direction.

Voluntary Termination of Self-Direction of Services

An individual who has elected self-direction and continues to be eligible for the Self-Determination Waiver Program may voluntarily elect to terminate self-direction as the method of service provision and receive waiver services through the standard service delivery method. To voluntarily terminate self-direction of services, the participant must contact the ~~DIDS~~ DIDD case manager. The case manager will seek to identify and address any issues the individual may have with self-directing that can be resolved so the person may continue self-directing services. If the individual still wants to voluntarily terminate self-direction of services, the case manager will assist the individual in transitioning to traditional provider agency services without interruption in service. The case manager will assist the individual in choosing a provider from the available qualified providers and will revise the participant's ISP.

m. Involuntary Termination of Participant Direction.

Involuntary Termination of Self-Direction of Services

An individual who has elected self-direction and continues to be eligible for the Self-Determination Waiver Program may be involuntarily required to terminate self-direction as the method of service provision and receive waiver services through the standard method of service delivery under the following circumstances:

1. The person is no longer enrolled in TennCare.
2. The person is no longer enrolled in the Self Determination waiver.
3. The person no longer needs any of the home and community based services eligible for self-direction as specified in the individual support plan.
4. The person is no longer willing or able to serve as the employer of record for his or her employees and to fulfill all of the required responsibilities of self-direction, and does not have a qualified representative who is willing and able to serve as the employer of record and to fulfill all of the required responsibilities for self-direction.
5. The person is unwilling to sign a risk agreement which identifies and addresses any additional risks associated with the person's decision to participate in self-direction, or the risks associated with the person's decision to participate in self-direction pose too great a threat to the person's health, safety, and welfare.
6. The person's health, safety, and welfare may be in jeopardy if the person or his or her representative continues to employ a worker but the person or representative does not want to terminate the worker.
7. The person does not have an adequate back-up and emergency plan for self-determination.
8. The person's needs cannot be safely and appropriately met in the community while participating in self-direction.
9. The person or his or her representative for self-direction or self-directed workers he or she wants to employ are unwilling to use the services of the department's contracted FA/SB to perform required financial administration and supports brokerage functions.
10. The person or his or her representative is unwilling to abide by the requirements of the Self Determination Waiver self-direction program.
11. If a person's representative fails to perform in accordance with the terms of the representative agreement and the health, safety, and welfare of the person is at risk, and the person wants to continue to use the representative.
12. If the person has consistently demonstrated that he or she is unable to manage, with sufficient supports, including appointment of a representative, his or her services and the case manager or FA/SB has identified health, safety, and or welfare issues.
13. The case manager has determined that the health, safety and welfare of the person may be in jeopardy if the person continues to employ a worker but the person and the representative do not want to terminate the worker.
14. Other significant concerns identified and reported and or documented by the person's supports broker, case manager or member of the Circle of Support regarding the person's participation in self-direction which jeopardize the health, safety or welfare of the person.

~~1. The participant does not carry out his/her responsibilities under self-determination; or~~
~~2. Continued use of self-determination as a method of service delivery poses a health and welfare risk.~~

In the event that the self-direction option is involuntarily terminated, the person's ISP will be revised. Termination of the self-direction option will not affect the participant's ongoing receipt of services specified in the ISP. Services, however, will be provided through the standard method of service delivery.

n. Goals for Participant Direction.

E-2: Opportunities for Participant-Direction
b. ii. Participant-Directed Budget

Methodology for the Uniform Calculation of the Individual Self-Determination Budget:

Each waiver participant will have an individual budget. The individual budget is defined as the total cost of all waiver services authorized in the Individual Support Plan. The amount of the budget shall be based on the type and amount of services needed to address the participant's needs and personal outcomes, and to assist the participant to achieve the goals and objectives contained in the ISP.

The individual budget shall include the cost of services in the Supports for Community Living Service Category and the Professional and Technical Support Services Category. As provided in Appendix B, the amount of the individual budget for the services under the Supports for Community Living Category shall not exceed $23,000 unless an exception has been approved. The amount of the individual budget for the services under the Professional and Technical Support Services Category shall not exceed $7,000 unless an exception has been approved. Unless supplemental Emergency Assistance has been authorized, the total amount of the individual budget is subject to a $30,000 per year per waiver participant limitation. In the event that a person's budget has reached $30,000 and the person experiences an emergency or crisis (e.g., a family member can no longer provide the level of support that was previously provided), supplemental Emergency Assistance up to $6,000 may be provided as indicated in Appendix B. The total budget for all waiver services, including Emergency Assistance, shall not exceed $36,000 per year per participant.

The foregoing basic methodology for calculating the individual budget will be employed regardless of whether the participant elects self-direction. As a consequence, the budget calculation methodology is uniform for all participants in the program. If a participant elects to directly manage services which may be participant-managed, the self-determination budget for those services shall be an annual amount included as part of the base individual budget. Within this amount, the participant may:

1. Select and/or recruit service providers.

2. Negotiate payment rates with the providers of participant-managed services up to the state-determined maximum payment rate for the service under the agency-directed method of service delivery.

3. Change the amounts of participant-managed services specified and approved in the Individual Support Plan so long as the change is consistent with the needs, goals and objectives identified in the ISP and the health/welfare of the participant is not compromised. When a change is made, the participant must notify the ~~DIDS~~ DIDD regional office case manager who is responsible for notifying the Financial Administration entity. ~~A change in the participant's ISP is not necessary when such changes are made.~~ The participant's ISP shall be updated to reflect the change in amounts of participant-managed services. In addition, the ~~DIDS~~ DIDD case manager and the Financial Administration entity shall maintain documentation of such changes for audit purposes.

4. Schedule and reschedule services.

~~The current Fiscal Administration contract (Contract number: FA-07-17115-00) requires Supports Brokers to provide training to waiver participants who elect self-direction and assist "…in recruitment of providers of participant-managed services" and "…in managing and monitoring the self-determination budget"~~

~~DIDS~~ DIDD provides information about rate methodology, including maximum reimbursement schedules, to the contracted Financial Administration entity. The Financial Administration entity is responsible for ensuring that staff employed as supports brokers have access to this information and are trained to assist people who elect self-direction in establishing provider/staff reimbursement rates that are consistent with effective management of the individual budget. ~~DIDS is arranging for current TennCare maximum reimbursement rate schedules to be posted on the DIDS website.~~ As indicated in Section G of the work plan, ~~DIDS~~ DIDD intends to develop educational/resource materials for people who elect self-direction that clearly identify the requirements and responsibilities associated with self-direction and provide guidance in meeting such requirements and responsibilities (Action Steps G.4.-G.6.). The educational/resource materials developed will specifically include information pertaining to developing an individual budget and determining reimbursement rates for staff employed to provide waiver goods and services that the waiver participant has chosen to manage. Following TennCare approval, such resource materials will be provided to the contracted Financial Administration entity for distribution to people who have already elected self-direction and those who subsequently consider or elect self-direction of services. Available resource materials will also be posted on the ~~DIDS~~ DIDD website.

iii. Informing Participant of Budget Amount

The Tennessee Self-Determination waiver program methodology is explained to the individual, individual's representative or family member by the ~~DIDS~~ DIDD case manager as part of ISP development. During the ISP development process, all individuals and families will receive an orientation to self-direction. Individuals and families who express an interest in self-direction will be provided more in-depth information, including the added responsibilities that accompany participant management of services and its benefits. This information will include examples of a self-determination budget and how it may be managed. Requests for adjustments in the budget amount or in waiver services are submitted through the ~~DIDS~~ DIDD case manager.

In addition, an individual who elects self-direction will have a supports broker who among other activities will provide assistance to the individual in the managing and monitoring of the individual self-determination budget.

b. Participant - Budget Authority
v. Expenditure Safeguards.

~~DIDS~~ DIDD case managers assist participants in identifying their needs and preferences, and selecting, obtaining and coordinating services and then perform ongoing monitoring through quarterly face-to-face monitoring visits and completion of a monthly status review of the Individual Support Plan (plan of care).

For participants who self-direct services, the Financial Administration entity prepares and submits monthly Self-Determination budget status reports to the participant and to the case manager. In addition, the Financial Administration entity is required to alert the ~~DIDS~~ DIDD regional office whenever the pattern of expenditures reveals the potential that the self-determination budget would be prematurely exhausted.

The ~~DIDS~~ DIDD case manager will review the monthly expenditure report to identify potential problems, including potential over-expenditure of funds or expenditure patterns that might indicate that the participant is having difficulty in accessing authorized services. The ~~DIDS~~ DIDD case manager will follow-up with the participant and/or the Financial Administration/Supports Brokerage entity.

APPENDIX F: PARTICIPANT RIGHTS

Appendix F-1: Opportunity to Request a Fair Hearing

The Medicaid Agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care or who are denied the service(s) of their choice, or the provider(s) of their choice.

PROCESS:
The following describes the process for informing eligible individuals of their right to request a fair hearing under 42 CFR Part 431, Subpart E:

1. A plain language explanation of appeal rights shall be provided to enrollees upon enrollment in the waiver.

2. ~~DIDS~~ DIDD shall give a plain language written notice to the enrollee of any action to delay, deny, terminate, suspend, or reduce waiver services or of any action to deny choice of available qualified providers.

3. Notice must be received by the enrollee prior to the date of the proposed termination, suspension, or reduction of waiver services unless one of the exceptions exists under 42 CFR 431.211-214.

4. An enrollee has the right to appeal the adverse action and to request a fair hearing.

5. Appeals must be submitted to the Bureau of TennCare within thirty (30) calendar days of receipt of notice of the adverse action. Receipt of any notice shall be presumed to be within five (5) calendar days of the mailing date.

6. Reasonable accommodations shall be made for persons with disabilities who require assistance with the appeal process.

7. Hearings shall be held pursuant to the provisions of the Tennessee Uniform Administrative Procedures Act and shall be held before an impartial hearing officer or administrative judge.

8. A written hearing decision shall be issued within ninety (90) calendar days from the date the appeal is received. If the hearing decision is not issued by the 90th day, the waiver service may under specified circumstances be provided until an order is issued.

9. Waiver services shall continue until an initial hearing decision if the enrollee appeals and requests continuation of waiver services within ten (10) calendar days or five (5) calendar days, as applicable under 42 CFR 431.213-214 and 431.231, of the receipt of the notice of action to suspend or reduce ongoing waiver services. If the denial decision is sustained by the hearing, recovery procedures may be instituted against the enrollee to recoup the cost of any waiver services furnished solely by reason of the continuation of services due to the appeal.

Appendix F-3: State Grievance/Complaint System

b. Operational responsibility:

Bureau of TennCare and the Department of Intellectual and Developmental Disabilities (~~DIDS~~ DIDD - the Operating Agency).

c. Description of System. Resolution of complaints filed with TennCare

All complaints received by TennCare will be referred to the Quality Review Unit Manager or designee. A complaint is any allegation or charge against a party, an expression of discontent, or information as it pertains to wrong doing affecting the well-being of a service recipient. All complaints will be maintained on a complaint log. Each HCBS waiver will have a separate log. Entries to the complaint log will include the following elements:

1. The name of the waiver service recipient(s)

2. Social security numbers of the service recipient(s) (if not available from the complainant, to be retrieved from the InterChange System)

3. The name and phone number of the individual reporting the complaint

4. The nature of the complaint(s) or problem(s)

5. The date the ~~Division of Intellectual Disabilities Services~~ Department of Intellectual and Developmental Disabilities (DIDD) was notified of the complaint. If the complainant expressly requests that ~~DIDS~~ DIDD not be notified, the reason must be documented.

6. If the complaint is such that appeal rights are involved, documentation that the complainant was informed of such rights.

7. If appeal is requested by the complainant, documentation of the date of referral to the appropriate entity with request for a copy of the final directive.

8. Any actions taken to research, investigate, or resolve the complaint or problem, including dates of such action

9. The results of complaint investigations, including complaints that were validated and a general description of actions taken to resolve complaints (e.g., Corrective Action Plans)

Upon receiving a complaint, designated TennCare staff will determine from the complainant any provider or ~~DIDS~~ DIDD staff involved in resolving the issue prior to the complainant's contact with TennCare and the extent to which prior ~~DIDS~~ DIDD or provider actions have been successful in resolving the problem.

If the complainant indicates that ~~DIDS~~ DIDD has been notified of the complaint/problem and has not responded timely or satisfactorily, TennCare staff will contact the appropriate ~~DIDS~~ DIDD staff by telephone within two (2) working days (unless requested not to do so by the complainant) to advise of the nature of the complaint and request that all information pertaining to the complaint be provided within five (5) working days, including any actions taken to resolve the complaint or problem as of the date of the contact.

A follow-up memo will be sent to ~~DIDS~~ DIDD via fax or mail to document the date of ~~DIDS~~ DIDD notification, the request for related ~~DIDS~~ DIDD information, and the expected date of receipt.

~~DIDS~~ DIDD will be required to collect any requested information from involved providers and submit it to the TennCare Division of Long Term Services and Supports ~~Developmental Disability Services~~. Upon receipt of information regarding ~~DIDS~~ DIDD completed actions or anticipated actions, a determination will be made as to whether adequate steps have been or are being taken to resolve the issue.

TennCare and ~~DIDS~~ DIDD will work cooperatively to achieve complaint resolution. Once TennCare and appropriate ~~DIDS~~ DIDD staff have agreed on a course of action to resolve the problem, the complainant and any providers involved will be notified in writing of the proposed solution and expected date of resolution. Sufficient follow-up contacts to the complainant and ~~DIDS~~ DIDD will be made by TennCare Waiver staff to determine if the problem has been adequately resolved. ~~DIDS~~ DIDD will be responsible for providing adequate follow-up documentation as requested by TennCare Waiver staff to document that the agreed upon actions were completed. All complaints filed with TennCare are expected to be resolved within 30 calendar days. ~~DIDS~~ DIDD will be required to provide written notification of complaint resolution to designated TennCare staff for and will be required to advise TennCare of any TennCare complaints for which resolution cannot be achieved within targeted timeframes. TennCare will continue to monitor remedial actions until it is determined that the problem is resolved and the complaint can be closed. Outstanding complaint cases will be discussed at the monthly TennCare/~~DIDS~~ DIDD ~~Protection From Harm~~ meetings.

The complainant will receive written notification from designated TennCare, including the data the complaint was considered resolved and closed, a summary of information discovered, and remedial actions taken.

~~DIDS~~ DIDD Complaint Resolution System

~~DIDS~~ DIDD employs a Central Office Complaint Resolution Coordinator and Regional Office complaint resolution staff to receive complaints and work with waiver participants and their families, as well as contracted providers, to determine the appropriate actions needed to resolve complaints and ensure that actions are implemented in a timely manner (within a thirty day targeted timeframe. Complaint coordination staff receive training in mediation techniques.

~~DIDS~~ DIDD collects information regarding waiver participant familiarity with the complaint process through the participant satisfaction survey. Information collected is compiled and reported to TennCare in monthly data files and the Quality Management Report. ~~DIDS~~ DIDD also reports monthly ~~DIDS~~ DIDD complaint data, including the number and type of complaints received, referral sources, remedial actions, and timeframes for achieving resolution. TennCare monitors ~~DIDS~~ DIDD complaint remedial actions on a monthly basis and advises ~~DIDS~~ DIDD of any that require further action.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

b. State Critical Event or Incident Reporting Requirements: The ~~Division of Intellectual Disabilities Services (DIDS)~~ Department of Intellectual and Developmental Disabilities (DIDD) requires reporting of all incidents classified as "Reportable". This applies to employees and volunteers of contracted service providers, as well as ~~DIDS~~ DIDD employees who witness or discover such an incident.

Reportable incidents categorized as abuse, neglect, exploitation, serious injury of unknown cause, or death must be reported to ~~DIDS~~ DIDD within four hours of being witnessed or discovered. Abuse and neglect must also be reported to the Tennessee Department of Human Services, Adult Protective Services, or the Tennessee Department of Children's Services, Child Protective Services, as applicable.

All other incidents that meet the ~~DIDS~~ DIDD definition of a "Reportable Incident" (e.g., medical, behavioral and psychiatric incidents; accidents that require "external" intervention such as an emergency room visit or a call to the police; and staff misconduct that does not result in harm to a participant) must be reported to ~~DIDS~~ DIDD by the next business day.

c. Participant training and Education: Participants and their families or legal representatives are provided the ~~DIDS~~ DIDD Family Resource Guide which includes information on how to report abuse, neglect, and exploitation to ~~DIDS~~ DIDD.

~~DIDS~~ DIDD also conducts ongoing family training sessions across the state in which ~~DIDS~~ DIDD services and requirements are presented and discussed.

d. Responsibility of review of and response to Critical Events or Incidents: The ~~DIDS~~ DIDD Protection From Harm Unit receives allegations of abuse, neglect, exploitation, serious injuries of unknown cause and suspicious deaths. All such incidents are investigated by trained ~~DIDS~~ DIDD investigators who interview the participant, service provider, and all available witnesses. The ~~DIDS~~ DIDD investigators examine the incident scene and collect other available relevant circumstantial evidence (written statements, expert medical opinions as needed, etc.). Based on the preponderance of the cited evidence, each allegation is determined to either be substantiated or unsubstantiated, and a formal written Investigation Report is generally completed within 30 days of the allegation being witnessed or discovered. (In some extraordinary situations, such as a pending criminal investigation, the ~~DIDS~~ DIDD investigation may take longer than 30 days.) ~~DIDS~~ DIDD requires the waiver service provider to develop and implement a written management plan that addresses the issues and conclusions specified in the ~~DIDS~~ DIDD Investigations report within 14 days of the completion of the Investigation Report.

For all other "Reportable Incidents", ~~DIDS~~ DIDD requires the person witnessing or discovering the incident to ensure that a written incident report form is forwarded to the responsible waiver service provider and to ~~DIDS~~ DIDD. The service provider is required by ~~DIDS~~ DIDD to have incident management processes and personnel in place sufficient to review and respond to all "Reportable Incidents". The service provider is required to ensure that the incident and the initial response to the incident are documented on the incident report form, to review all provider incidents weekly for the purpose of identifying any additional actions needed, and to organize all incident information in a way that would facilitate the identification of at-risk participants as well as other trends and patterns that could be used in agency-level incident prevention initiatives.

e. Responsibility for Oversight of Critical Incidents and Events. The ~~Division of Intellectual Disabilities Services~~ Department of Intellectual and Developmental Disabilities (DIDD) is the agency responsible for overseeing the reporting of and response to all "Reportable Incidents".

Investigation reports involving allegations of abuse, neglect, or exploitation are reviewed by the ~~DIDS~~ DIDD Director of Investigations and are available for review by the Bureau of TennCare.

All "Reportable Incidents" received by ~~DIDS~~ DIDD are reviewed for completeness of information (with follow-up for more information if needed), are categorized according to written criteria, and are entered into an electronic database. This database provides data management capabilities including the ability to:

1. Generate "alerts" of individual incidents to designated ~~DIDS~~ DIDD staff for follow-up as needed;

2. Support reporting to external entities (e.g., TennCare); and

3. Support internal ~~DIDS~~ DIDD trends analysis and reporting functions such as:

a. Identification of at-risk participants;
b. Identification of employees or contract staff with multiple episodes of substantiated abuse, neglect, and exploitation allowing voluntary screening of prospective employees by service providers during the hiring process;
c. Identification of at-risk situations (e.g., data on injuries from falls);
d. Detailed "profiling" of identified service providers and comparison between service providers; and
e. Distribution of monthly reports to ~~DIDS~~ DIDD management and other staff.

All Incident and Investigation reports completed by ~~DIDS~~ DIDD are available for TennCare review. Monthly data files and Quality Management Reports are submitted to TennCare containing information about the number and types of critical incidents reported, the number of investigations initiated and completed, the number and percentage of substantiated allegations, and time frames for completion of investigations. TennCare reviews incident and investigation data to ensure appropriate and timely remediation of identified findings. TennCare notifies ~~DIDS~~ DIDD, on a monthly basis, of any investigation findings that are not acceptably remediated. ~~DIDS~~ DIDD is required to provide additional information and/or take additional remedial action until TennCare can determine that appropriate remediation has taken place.

G-2 Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of restraints or Seclusion
i. Safeguards Concerning the Use of Restraints or Seclusion. The use of seclusion is prohibited. Restraints may be used only when necessary to protect the participant or others from harm and when less intrusive methods have been ineffective. Take downs and horizontal restraint are prohibited. The following mechanical restraints are prohibited: restraint vest, camisoles, body wrap, devices that are used to tie or secure a wrist or ankle to prevent movement, restraint chairs or chairs with devices that prevent movement, and removal of a person's mobility aids such as a wheelchair or walker.

Staff are required to use positive proactive and reactive strategies for preventing and minimizing the intensity and risk factors presented by an individual's behavior whenever possible in order to minimize the use of personal and mechanical restraint.

Emergency personal restraint, mechanical restraint, or emergency medication is used only as a last resort to protect the person or others from harm. The use of emergency personal restraints or mechanical restraints requires proper authorization, is limited to the time period during which it is absolutely necessary to protect the individual or others, and is not permitted as a punishment by staff, for staff convenience, or in lieu of person-centered programmatic services. The provider agency director or designee must ensure that staff are able to correctly apply the emergency personal restraint or mechanical restraint.

In cases where a behavior analyst assesses the level of behavior need and risk factors and the planning team concurs, the use of personal or manual restraint may be specified as an intervention in a behavior support plan that is reviewed and approved by a Behavior Support Committee and a Human Rights Committee. Informed consent must be obtained from the participant or the participant's guardian/conservator. Such use of restraint must be justified as a necessary component of the least restrictive, most effective behavioral intervention. The use of personal or mechanical restraint is limited to the time period during which it is absolutely necessary to protect the individual or others and is not permitted as a punishment by staff, for staff convenience, or in lieu of person-centered programmatic services. Provider staff who are responsible for carrying out the behavior support plan must be trained on the plan prior to implementation.

Emergency use of personal restraint or mechanical restraint constitutes a reportable incident and as such must comply with ~~DIDS~~ DIDD reporting procedures. The case manager must be notified of each use of emergency personal or mechanical restraint within one (1) working day.

The use of a psychotropic medication requires a formal diagnosis and informed consent from the service recipient or the service recipient's legal representative. In addition, the use of psychotropic medications requires review by a human rights committee. When emergency psychotropic medications are administered pursuant to physician's orders, a Reportable Incident Form must be completed and submitted.

ii. State Oversight Responsibility. The ~~Division of Intellectual Disabilities Services~~ Department of Intellectual and Developmental Disabilities (DIDD) is the state agency responsible for overseeing the use of restraints and seclusion and ensuring that safeguards concerning their use are followed. Each month the Behavior Services Director in the ~~DIDS~~ DIDD Regional Office reviews a sample of behavior support plans for proper design and implementation and the application of restraints. Regional Office reviews are forwarded to the ~~DIDS~~ DIDD ~~Central Office Behavior Services Director~~ Director of Behavior and Psychological Services for analysis. Restraint use is reported at monthly Quality Management Committee meetings.

b. Use of Restrictive Interventions:

i. Safeguards Concerning the Use of Restrictive Interventions. Restrictive interventions are only implemented as part of a behavior support plan approved by a Behavior Support Committee and a Human Rights Committee and after ~~signed~~ informed consent has been obtained from the service recipient or the service recipient's legal representative. The emphasis, however, is placed on developing effective behavior support plans that do not require the use of restrictive interventions. If the use of restrictive interventions is required, such use is reevaluated with the goal of reducing or eliminating the continued use of the intervention as clinical progress permits.

The following types of restricted interventions are permitted:

1. Contingent effort;
2. Escape extinction;
3. Non-exclusion and *exclusion time-out;
4. Negative practice;
5. Contingent use of personal property or freedoms;
6. Delay of meals;
7. *Manual restraint;
8. Overcorrection, positive practice;
9. Response cost;
10. Satiation;
11. Substitution of food/meals;
12. Mechanical restraint;
13. *Protective equipment;
14. Required (forced) relaxation; or
15. Sensory extinction.

*Restraints and protective equipment may be used only when necessary to protect the service recipient or others from harm and when less intrusive methods have been ineffective. The application of restraint or protective equipment and exclusionary time-out to a specific location must be implemented carefully to ensure protection from harm and to protect the service recipient's rights.

Behavior support plans including restricted interventions must be written by a ~~DIDS~~ DIDD - approved Behavior Analyst. In special cases, the behavior analyst may request a variance from current policies given a person's unique needs. A variance must be included in a behavior support plan and must be reviewed and approved by the individual and/or guardian or conservator, the Circle of Support, a Behavior Support Committee and Human Rights Committee, and by the ~~State Behavior Analyst Coordinator~~ Director of Behavior and Psychological Services . Final authorization must be provided by the ~~Deputy Commissioner of Intellectual Disability Services~~ Commissioner of Intellectual and Developmental Disabilities or designee.

The application review and approval process for behavior services providers is managed by the ~~DIDS~~ DIDD ~~Central Office Behavior Services Director~~ Director of Behavior and Psychological Services. Behavior analysts must have a graduate degree and a minimum of 12 graduate hours in behavior analysis. Courses must focus upon behavior analysis, rather than more generic topics in the discipline for which the graduate degree was awarded. The courses should address the following issues in applied behavior analysis: ethical considerations in the practice of applied behavior analysis; definitions, characteristics, principles, processes and concepts related to applied behavior analysis; behavioral assessment and the selection of intervention strategies and outcomes; experimental evaluation of interventions; measurement of behavior and displaying/interpreting behavioral data; behavioral change procedures and systems support.

A ~~DIDS~~ DIDD - approved behavior analyst must complete the following ~~DIDS~~ DIDD -required training courses as specified in the Provider Manual and ~~DIDS~~ DIDD Staff Development plan. Once the behavior support plan has been developed by the behavior analyst, direct support staff are required to receive training on the implementation of the behavior support plan prior to working with the service recipient.

ii. State Oversight Responsibility. The ~~Division of Intellectual Disabilities Services~~ Department of Intellectual and Developmental Disabilities (DIDD) is the state agency responsible for overseeing the use of restrictive interventions and ensuring that safeguards concerning their use are followed. Each month the Behavior Services Director in the ~~DIDS~~ DIDD Regional Office reviews a sample of behavior support plans for proper design and implementation and the application of restrictive interventions. Regional Office reviews are forwarded to the ~~DIDS~~ DIDD ~~Central Office Behavior Services Director~~ Director of Behavior and Psychological Services for analysis. Restraint use is reported at monthly Quality Management Committee meetings.

APPENDIX G-3: MEDICATION MANAGEMENT AND ADMINISTRATION

Medication Management and Follow-Up

i. Responsibility: All waiver service providers who administer medications to participants have ongoing responsibility for monitoring participant medication regimens. They are responsible for ensuring that medications are administered appropriately and that medication administration is documented in accordance with ~~DIDS~~ DIDD record-keeping requirements. Providers must have written policies and procedures for medication administration that have been reviewed and approved by a ~~DIDS~~ DIDD Regional Nurse. On an ongoing basis, providers are required to complete a medication variance form for all medication variances. If the medication variance caused, or is likely to cause, harm to the service recipient, the provider must submit a copy of the medication variance form and a Reportable Incident Form to the ~~DIDS~~ DIDD Regional Office. The provider agency submits a monthly medication variance trend report to the ~~DIDS~~ DIDD Regional Office Nursing Director.

In addition, ~~DIDS~~ DIDD is responsible for oversight of medication management. During annual quality assurance surveys, which involve a randomly selected sample of service recipients, ~~DIDS~~ DIDD Regional Quality Assurance surveyors review the service recipient's Medication Administration Record (MAR) and medication regimen to identify potentially harmful practices and to ensure compliance with the MAR record-keeping and medication administration requirements. Medication variance (error) reports are also reviewed. During the surveys, the ~~DIDS~~ DIDD Regional Quality Assurance surveyors review the medication management practices to ensure that:

a. The Medication Administration Record correctly lists all medications taken by the person supported;
b. The Medication Administration Record is updated, signed, and maintained in compliance with ~~DIDS~~ DIDD record-keeping requirements;
c. All medications are administered in accordance with physician's orders;
d. Medications are administered by appropriately trained staff;
e. Medications are kept separated for each service recipient and are stored safely, securely, and under appropriate environmental conditions.

In addition to the monitoring process described above, if a service recipient is using a behavior modifying medication (psychotropic medication), the ~~DIDS~~ DIDD Regional Quality Assurance surveyors will determine whether (1) there is documentation of voluntary, informed consent for the use of the medication; (2) the service recipient or the service recipient's family member or legal representative was provided information about the risks and benefits of the medication; and (3) the use of a behavior modifying medication as a restricted intervention underwent review by the Behavior Support Committee and the Human Rights Committee.

During the quality assurance surveys, ~~DIDS~~ DIDD quality assurance staff also review personnel records to ensure that licensed staff who administer medications are appropriately licensed and that unlicensed staff who are permitted by state law to administer medications have documentation of the required training.

ii. **Methods of State Oversight and Follow-Up.**

~~DIDS~~ DIDD is responsible for oversight of medication management. During annual Provider Performance Surveys,~~ DIDS~~ DIDD reviews the service recipient's Medication Administration Record (MAR) to identify potentially harmful practices and to ensure compliance with documentation requirements. Medication error reports are reviewed. Personal Records are reviewed to ensure that licensed staff who administer medications are appropriately licensed and that unlicensed staff who are permitted by state law to administer medications have documentation of the required training. When the ~~DIDS~~ DIDD quality assurance surveyors identify potentially harmful medication administration/management practices, the surveyors notify the provider during the survey and then review such issues during the exit conference at the end of the survey. In addition, the provider is notified in writing of any problems identified during the survey, and the provider is required to take appropriate action to resolve such problems in a timely manner. When deficiencies are identified, the ~~DIDS~~ DIDD Regional Director is notified and is responsible for ensuring that ~~DIDS~~ DIDD Regional Office staff follow up to verify timely and appropriate resolution.

Providers are required to complete a reportable incident form for medication errors. If the medication error caused, or is likely to cause, harm, the provider must submit a copy of the Reportable Incident Form to the~~ DIDS~~ DIDD Regional Office. Regional Office staff review medication error incident forms for completeness and determination of the nature of the incident. Provider agencies are responsible for identifying medication error trends. ~~DIDS~~ DIDD extracts data from the Incident and Investigations database on a monthly basis to determine trends that must be addressed either with individual provider agencies or systemically. Medication error data is presented and discussed during the monthly State Quality Management Committee Meeting.

c. Medication Administration by Waiver Providers

ii. State Policy.

The Nurse Practice Act in Tennessee generally prohibits administration of medication by unlicensed individuals. There is, however, a statutory exemption for providers who administer medications to individuals receiving services through the ~~Division of Intellectual Disabilities Services (DIDS)~~ Department of Intellectual and Developmental Disabilities (DIDD). This exemption permits certain unlicensed direct support staff to administer medications after successfully completing a medication administration training program developed by ~~DIDS~~ DIDD. After completing the training program, the individual may administer medications within specified parameters and in accordance with the physician's order; however, the individual is not permitted to administer medications when such administration requires judgment, evaluation, or assessment before the medication is administered. The individual must make a written record of any medication that is administered, including the time and amount taken.

iii. Medication Error Reporting.

The provider agency is required to complete the approved ~~DIDS~~ DIDD incident form used to report all medication errors. This form includes information that specifies the name of the physician notified and the date and time of notification. Medication errors are reported to designated ~~DIDS~~ DIDD Regional Office staff. ~~DIDS~~ DIDD reviews medication error reports monthly to determine trends that must be addressed with contracted providers or systemically.

(b) Specify the types of medication errors that providers are required to record:

Providers are required to record a medication error whenever a medication was given in a way that was not consistent with the physician's orders, including the following:

1. Medication was given to the wrong person;
2. Medication was given at the wrong time;
3. Wrong dose of medication was given;
4. Wrong form of medication was given (e.g., tablet instead of liquid form);
5. Wrong medication was given;
6. Medication was given by the wrong route of administration;
7. Failure to give the medication; or
8. Medication was not prepared according to the physician's orders (e.g., was not crushed).

(c) Specify the types of medication errors that providers must report to the State:

A medication error variance must be reported if it:
1. Requires intervention and caused, or is likely to cause, the person temporary harm;
2. Caused, or is likely to cause, temporary harm requiring hospitalization;
3. Caused, or is likely to cause, permanent harm to the person;
4. Resulted in a near death event (e.g., anaphylaxis, cardiac arrest); or
5. Resulted in or contributed to the person's death.

iv. State Oversight Responsibility.

The state agency responsible for monitoring the performance of waiver providers in the administration of medications to service recipients is the ~~Division of Intellectual Disabilities Services~~ Department of Intellectual and Developmental Disabilities (DIDD). Provider Performance Surveys are conducted annually by the ~~DIDS~~ DIDD Regional Quality Assurance Units to assess the performance of waiver providers in the administration of medications. All waiver service providers who administer medications to service recipients are subject to Provider Performance Surveys and are monitored annually unless they meet established criteria for reduced frequency of monitoring. During Provider Performance Surveys, ~~DIDS~~ DIDD Regional Office nurses serve as consultants to non-nurse surveyors.

The following Quality Assurance Indicators are evaluated during Provider Performance Surveys:

1. Medication errors are reported and addressed in a timely manner.

Compliance with requirements to detect, respond to, and report medication errors in accordance with ~~DIDS~~ DIDD policy and procedures is assessed. Surveyors determine if the agency has developed and implemented effective procedures for oversight of medication administration and reporting medication errors.

2. The provider analyzes trends in medication errors and implements prevention strategies.

Monitoring is conducted to assess compliance with the requirement that the agency has policies and procedures in place for tracking and trending medication errors that include implementation of prevention strategies. Reviews are conducted to assess whether the agency has a self-assessment process to review medication administration errors; whether the agency reviews recommendations resulting from monitoring; and whether the agency has implemented corrective action in response to recommendations.

3. The person's record adequately reflects all the medications taken by the person.

Surveyors assess whether current physician's orders are present for each medication received by the service recipient.

4. Needed medications are provided and administered in accordance with physician's orders.

Surveyors assess documentation of medication administration or refusal, identification of medication errors with required action being taken, and monitoring of medication self-administration.

5. Only appropriately trained staff administer medication.

Surveyors assess whether licensed staff who administer medications have a current license, unlicensed staff who administer medications have received appropriate training, whether there has been appropriate delegation of medication administration by a registered nurse, and whether the provider conducts ongoing monitoring of staff administering medications.

6. Medication administration records are appropriately maintained.

Surveyors assess compliance with the requirement that agencies must develop and implement procedures for oversight and completion of the Medication Administration Records. Surveyors also assess compliance with the requirement that providers must maintain information on medication side-effects and that the MAR matches prescription labels and physician's orders.

7. Storage of medication ensures appropriate access, security, separation, and environmental conditions.

Surveyors assess the provider's compliance with the requirement that provider medication administration policy address procedures for and monitoring of medication storage and disposal.

APPENDIX G: PARTICIPANT SAFEGUARDS
QUALITY IMPROVEMENT: HEALTH AND WELFARE

a.i.2. # and % of participant satisfaction survey respondents who indicated knowledge of how to report a complaint. (~~DIDS~~ DIDD People Talking to People Consumer Survey question: "Do you know how to report a complaint?"). % = # of survey respondents able to relate how to appropriately report a complaint / total number of waiver participants who responded to this satisfaction survey question.
a.i.3. Number and percentage of participant satisfaction survey respondents who reported being treated well by direct support staff. (~~DIDS~~ DIDD People Talking to People Survey question: "Do your support staff treat you well or with respect?") % = # of survey respondents who reported being treated well by direct support staff / total # of waiver participants who responded to this survey question.
a.i.4. Number and percentage of participant satisfaction survey respondents who reported having sufficient privacy. (~~DIDS~~ DIDD People Talking to People Survey question: "Are you satisfied with the amount of privacy you have?") Percentage = # of survey respondents reporting sufficient privacy / total # of waiver participants who responded to this participant satisfaction survey question.
~~a.i.5. Number and percentage of critical incidents that were investigated, by type. Percentage = number of critical incidents investigated, by type / total number of critical incidents reported, by type.~~
~~a.i.6. # & % of waiver participants for whom a critical incident was reported and investigated, by type of incident. Percentage = number of unduplicated waiver participants for whom a critical incident was reported and investigated, by type of incident / total number of waiver participants.~~
~~a.i.7. Average number of critical incidents per waiver participant. Average = total number of critical incidents / total number of waiver participants.~~
a.i.8. Number and percentage of ~~DIDS~~ DIDD investigations by critical incident type completed within 30 calendar days. Percentage = number of investigations by critical incident type completed within 30 days / total number of investigations completed during the reporting period.
a.i.9. Number and percentage of investigations for which abuse, neglect, and/or exploitation was substantiated, total and by type. Percentage = number of substantiated allegations, total and by type / number of investigations, total and by type. ~~(delete "unknown or suspicious cause" "serious injury – suspicious unknown cause" from spreadsheet and QMR)~~
a.i.10. # and % of substantiated investigations, total and by type, (abuse, neglect, exploitation) for which appropriate corrective actions were verified within 45 days of issuance of the investigation report. % = # of substantiated allegations, total and by type, with corrective actions verified within 45 days of the report / total # of corrective actions verified during the reporting period. ~~(delete "unknown or suspicious cause" and "serious injury – suspicious or unknown cause" from spreadsheet and QMR)~~
a.i.11. Number and percentage of waiver participants for whom all critical incidents were reported as noted ~~there was no unreported critical incident noted in the primary record and/or the support coordination record.~~ Percentage = number of unduplicated waiver participants with no unreported incident noted / total number of waiver participants in the sample. ~~(delete "unknown or suspicious cause" and "serious injury – suspicious or unknown cause" from spreadsheet and QMR)~~
a.i.14. Number and percentage of deaths of unexplained or suspicious cause for which ~~a substantiated investigation determined the death to be a direct result of~~ abuse, neglect, or exploitation was substantiated. Percentage = number of deaths for which ~~of unexplained or suspicious cause identified as being a direct result of~~ abuse, neglect, or exploitation was substantiated / total Number of deaths of unexplained or suspicious cause.

~~a.i.15. Number and percentage of complaints received from each type of referral source. Percentage = number of complaints, by each type of referral source / total number of complaints received.~~
~~a.i.16. Number and percentage of complaints, by type, filed with DIDS DIDD. Percentage = number of each type of complaint filed / total number of complaints.~~

ii. Performance Measures a.i.1. and a.i.11.: A representative sample of waiver participants will be generated at the beginning of the waiver year. The sample will be divided as evenly as possible to collect data during the following twelve (12) months. For each waiver participant included in the sample, Waiver Individual Record Reviews will be conducted by designated ~~DIDS~~ DIDD Regional Office staff.

Performance Measures a.1.2. through a.1.4.: Data will be generated by contracted interviewers who complete ~~DIDS~~ DIDD People Talking to People Consumer Satisfaction Surveys. Interviewers are trained prior to conducting surveys regarding ~~DIDS~~ DIDD policies and procedures for identifying and reporting complaints and incidences of abuse, neglect, and exploitation.

Performance Measures a.i.5. through a.i.10., a.i.13., and a.i.14.: Data describing reportable critical incidents and investigations is entered on an ongoing basis into the ~~DIDS~~ DIDD Incident and Investigation Database. Monthly reports are generated that include data describing critical incidents reported and investigations initiated/completed during the month. This data will be compiled by designated ~~DIDS~~ DIDD staff and analyzed and trended monthly, year-to-date, and annually by ~~DIDS~~ DIDD Regional and State Quality Management Committees. ~~DIDS~~ DIDD also performs death reviews. Waiver service providers are required to report any death that is or may be a Suspicious, Unexpected, or Unexplained Death within four hours of discovery to designated ~~DIDS~~ DIDD Regional Office staff who record the circumstances of the death. Within one business day of the date of the death, a Notice of Death form must be completed by the waiver service provider and submitted to the ~~DIDS~~ DIDD Regional Director. Upon receipt of a Notice of Death form, the ~~DIDS~~ DIDD Regional Director or designee schedules a Preliminary Death Review Committee meeting. Within five business days of receipt of the Notice of Death, the Preliminary Death Review Committee shall perform a preliminary death review to determine if the death was Suspicious, Unexpected, or Unexplained. Any death determined to be Suspicious, Unexpected, or Unexplained shall trigger a ~~DIDS~~ DIDD Investigation, the preparation of a Clinical Death Summary, and a ~~DIDS~~ DIDD Death Review. The purpose of a ~~DIDS~~ DIDD Death Review is to conduct a comprehensive analysis of the relevant facts and circumstances, including the medical care provided, to identify practices or conditions which may have contributed to the death and to make recommendations, where necessary, to prevent similar occurrences.

Performance Measures a.i.15. through a.i.17.: Complaints filed with TennCare are referred to ~~DIDS~~ DIDD for resolution and are tracked on the ~~DIDS~~ DIDD Complaint Log. The ~~DIDS~~ DIDD Complaint Resolution Coordinator is responsible for reporting complaint resolution strategies and timeframes required for complaint resolution to the TennCare Complaint Coordinator. Complaints are expected to be resolved within 30 days of referral.

b. Methods for Remediation/Fixing Individual Problems

Performance Measures a.i.1.: When waiver participants are identified who have not received timely medical examinations, ~~DHDS~~ DIDD Regional Office staff will notify the Support Coordinator and any other providers, as applicable, to appropriately facilitate completion of a medical examination. Completion of the medical examination is expected within 30 days. Support Coordination and other provider agencies, as applicable, will be held accountable for taking appropriate personnel actions within 30 days to address individual ~~DHDS~~ DIDD case manager job performance, including, but not limited to training and retraining, verbal or written warning, suspension or termination. Support Coordination and other provider agencies, as applicable, will be required to report resolution dates to ~~DHDS~~ DIDD monthly.

Performance Measures a.i.2. through a.i.4.: When individuals do not know how to report complaints, the satisfaction survey interviewer will provide the appropriate information. The ~~DHDS~~ DIDD People Talking to People Director or designee will contact the waiver participant and/or person assisting the waiver participant who received complaint reporting instruction within 60 days to verify that the person who received information knows how to report complaint and has the appropriate written resources describing reporting processes. On a monthly basis, the ~~DHDS~~ DIDD People Talking to People Director will report information regarding the number of survey respondents who did not know how to appropriately report a complaint, as well as education provided and verifications completed, to ~~DHDS~~ DIDD Central Office staff responsible for data aggregation.

When waiver participants report that they have not been treated well or are dissatisfied with the amount of privacy allowed, the interviewer will determine how circumstances failed to meet expectations, when any specific event(s) described happened, and if the waiver participant wants to file a complaint or take other action, such as attending self-advocacy meetings or amending the Individual Support Plan. Negative responses to participant survey questions will be reported to the ~~DHDS~~ DIDD People Talking to People Director within three working days. The ~~DHDS~~ DIDD People Talking to People Director will ensure that a complaint is filed, if appropriate and in accordance with the waiver participant's wishes. The ~~DHDS~~ DIDD People Talking to People Director will track resolution of issues identified, as well as timeframes to achieve resolution. Complaints filed will be resolved in accordance with ~~DHDS~~ DIDD complaint resolution processes. ~~DHDS'~~ DIDD's goal is to resolve complaint issues within a 30 day time frame. Monthly information about complaints and complaint resolution, including types of complaint and referral sources, will be reported to ~~DHDS~~ DIDD Central Office staff responsible for data aggregation.

Performance Measures a.i.6. through a.i.10., a.i.13., and a.i.14.: Individual issues identified during ~~DHDS~~ DIDD investigations are reported to involved providers, who are required to respond within 30 days to identify corrective actions to be taken. ~~DHDS~~ DIDD Regional Office Investigations Follow-up staff are responsible for verifying that appropriate corrective actions were completed within 45 days of issuance of the investigation findings. Investigations results and follow-up actions will be reported monthly to ~~DHDS~~ DIDD Central Office staff responsible for data aggregation.

~~DHDS~~ DIDD Death Reviews are conducted within 45 business days of the individual's death; however, the time period may be extended by the ~~DHDS~~ DIDD ~~Deputy~~ Commissioner for good cause. The Regional Death Review Committee conducts a Death Review of any death determined to be Suspicious, Unexpected, or Unexplained and prepares detailed minutes including conclusions and recommendations for corrective actions. ~~DHDS~~ DIDD Regional Office staff ensure that the appropriate providers receive copies of the Committee's conclusions and recommendations. ~~DHDS~~ DIDD Regional Office Staff verify whether provider corrective actions are appropriately implemented within 45 days of the date the written conclusions/recommendations are.

Performance Measure a.i.11.: When unreported critical incidents are identified, the reviewer will immediately contact the appropriate provider to request that a late report be filed within two (2) working days and will verify that the complaint was actually filed either by observing the completed report and evidence of submission or by verifying receipt of the report with appropriate Regional Office staff. Failure to file timely critical incident reports may result in provider sanctions as specified in the Provider Agreement. The number of unreported critical incidents discovered will be reported by reviewers via entry into a database that is used by ~~DIDS~~ DIDD Central Office staff for data aggregation. Both a ~~DIDS~~ DIDD monthly Quality Management Reports and data files containing discovery and remediation data are submitted to TennCare.

~~(Continued on addendum)~~

APPENDIX H: QUALITY IMPROVEMENT STRATEGY
H-1: Systems Improvement

a. System improvements

i. When issues are identified that effect the quality of services offered through the waiver program, it is important that remediation strategies be implemented applicable to individual service recipients. It is equally important to evaluate the scope of the problem, so that broader improvements can address the potential for issues to affect other service recipients. The State's goal is to maintain a quality improvement system that not only identifies problems, but also assesses the scope of the problem and ensures that system redesign strategies are employed to proactively address issues that occur throughout a region or statewide. This section addresses the process of determining, developing, and implementing regional and statewide strategies.

Designated ~~DIDS~~ DIDD Central Office Compliance Unit staff will produce monthly ~~DIDS~~ DIDD State Quality Management Reports containing data produced for CMS assurance and sub-assurance performance measures. ~~DIDS~~ DIDD Regional Quality Management Reports will be reviewed by ~~DIDS~~ DIDD Regional Quality Management Committees.

~~DIDS~~ DIDD will post monthly discovery and remediation data files which allow TennCare to generate Compliance Summary Reports containing information about the number of Individual Record Reviews completed, percentage of compliance for each performance measure, number of findings remediated, and timeframes required for remediation. Performance measures with compliance percentages below 85% will be considered for systemic impact. For those determined systemic in nature, appropriate systemic actions will be determined and implemented.

~~DIDS~~ DIDD Regional Quality Management Committees will meet monthly to analyze Regional Data contained in the ~~DIDS~~ DIDD Regional Quality Management Report for the following purposes:

1. To determine the scope of each discovery or remediation problem identified (i.e., does the issue represent a finding for a single individual, does the data indicate multiple incidents of the same individual issues within a provider agency, or does the data indicate individual incidents of the same issue for service recipients receiving services from multiple waiver providers throughout the region?);
2. To determine if additional data is needed at the provider or regional level to determine the cause of the issue identified and/or the appropriate improvement strategy;
3. To develop recommendations for provider and regional level remediation strategies for consideration by the State Quality Management Committee; and

4. To evaluate the effectiveness of previously implemented provider or regional improvement strategies that were implemented to address previous regional level remediation problems.

Each month, the ~~DIDS~~DIDD State Quality Management Report ~~and the TennCare Compliance Summary Report~~ will be provided to the State Quality Management Committee, comprised of the ~~DIDS~~ ~~Deputy~~ Commissioner, senior ~~DIDS~~DIDD management staff.~~, and senior TennCare management staff~~. During State Quality Management Committee meetings, DIDD~~S~~ data for the previous month and cumulative year-to-date data will be reviewed and discussed. The state committee will:

1. Consider the analysis performed ~~DIDS~~ DIDD Regional Committees pertaining to current monthly, cumulative year-to-date, or annual findings;
2. Consider the appropriateness and adequacy of any improvement strategies recommended by ~~DIDS~~ DIDD Regional Committees and advise ~~DIDS~~ DIDD Regional Directors if additional measures are warranted;
3. Consider if aggregated data indicates a statewide system level issue;
4. Determine what improvement strategies for system level issues may be developed and implemented within 60 days and which would require long-term improvement strategies; and
5. Determine the best process for developing improvement strategies (e.g., individual staff development versus utilization of a workgroup for development) and assign lead responsibility to appropriate TennCare and/or ~~DIDS~~DIDD management staff.

~~TennCare has developed a form utilized by TennCare and DIDSDIDD for documenting performance measures scoring below 85%, discussion of reasons for the low performance score, identification of systemic issues, and determination of appropriate systemic remediation strategies.~~

b. System Design Changes

i. Monthly, year-to-date, and annual performance measure data will be monitored during the course of the subsequent year to determine if system redesign strategies employed to address regional and state level performance problems were effective in increasing compliance percentages. ~~DIDS~~ DIDD Regional Directors, with input and assistance provided by the ~~DIDS~~ DIDD Regional Quality Management Committee, will be responsible for monitoring provider level remediation and regional improvement strategies through analysis of performance measure data collected. Regional analysis will be presented to the State Quality Management Committee throughout the course of the waiver year. The ~~DIDS~~DIDD Commissioner will be responsible for monitoring and evaluating the effectiveness of state/system level improvement strategies with input and assistance provided by the State Quality Management Committee. The ~~Director Developmental Disability Services~~ ~~TennCare Director of MR HCBS Waiver Programs to~~ TennCare Director of Quality and Administration- Intellectual Disabilities Services, with assistance and input from TennCare Long Term Services and Supports ~~Developmental Disability Services~~ division staff, will have responsibility for monitoring and evaluating the effectiveness of improvement strategies specifically applicable to TennCare processes.

During the last State Quality Management Committee meeting prior to the end of the waiver year, the State Quality Management Committee will consider all regional and state level improvement strategies that were determined to be long-term improvements efforts due to requiring an extended period for development and/or implementation of corrective strategies. The committee will prioritize recommended long-term improvement strategies and determine which strategies can be implemented over the course of the following year.

The State Quality Management Committee will assign the appropriate ~~TennCare and/or DIDS~~DIDD senior management staff to develop a work plan for those measures to be addressed in the coming year.

ii. During the last State Quality Management Committee meeting prior to the end of the waiver year, committee members will consider whether performance measure data collected provide the information needed to assess waiver quality or whether aspects of the quality improvement system require revision. If determined that revision is warranted, ~~TennCare and DIDS~~DIDD senior management staff will be assigned to revise data collection forms, tools, processes, and/or data base formats to ensure that information needed to evaluate system performance is available. The state committee will also consider if existing performance measures are appropriate, if revision or deletion of existing measures should be undertaken, or if new performance measures should be added.

APPENDIX I: FINANCIAL ACCOUNTABILITY

I-1: Financial Integrity and Accountability
Financial Integrity:
A. Independent Audit

The ~~Division of Intellectual Disabilities Services (DIDS)~~ Department of Intellectual and Developmental Disabilities (DIDD) requires providers receiving $500,000 or more in aggregate state and federal funds to conduct an independent audit of the organization and to submit copies of the independent audit to the Tennessee Office of the Comptroller and to the ~~DIDS~~DIDD Office of Internal Audit.

The Independent Audit is an industry standard audit performed by a CPA/accounting firm to verify that the provider's business practices adhere to Generally Accepted Accounting Principles (GAAP). To ensure that auditors are truly independent, a preliminary step to all such audits includes written verification that no conflicts of interest exist between the auditor and the agency or firm being audited.

The ~~DIDS~~DIDD Office of Quality Management ~~Internal Audit~~ maintains a listing of all providers with "total annual funding" listed (i.e., aggregate state and federal funds). The Fiscal Accountability Review unit of the Office of Quality Management ~~Internal Audit~~ conducts annual on-site reviews of all providers receiving $500,000 or more in aggregate state and federal funds to determine compliance with the Independent Audit requirement. If reviewers find that an Independent Audit has not been completed within the past 12 months, a "finding" is issued and the provider is required to submit a written corrective action plan and, as soon as completed, a copy of the Independent Audit.

All provider types are included in the audit requirement. All providers, whether independent or part of a larger organization, are audited to ensure compliance with the Independent Audit requirement if they meet the $500,000 threshold.

B. Financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits:

Utilization Review Process - The Bureau of TennCare conducts utilization reviews of the HCBS waivers for persons with mental retardation to determine compliance with federal and state regulations and waiver requirements. Post-payment claim reviews to ensure that services are

appropriately documented and appropriately billed are conducted as part of the utilization review process.

Utilization reviews are conducted according to a predetermined audit schedule for the year. Reviews are conducted in each region of the state, and cover different waiver services each month. The service recipient sample is identified by entering the following data into the TennCare Interchange System: 1.) waiver provider number; 2.) dates of service; 3.) procedure code for the review; and 4.) paid status. The process includes a review of the approved service plan with the amount, frequency and duration, review of the billing documents and supporting documentation, and a comparison of all documents to adjudicated claims. Identified inconsistencies are documented and researched. Unsupported and/or inappropriate payments result in recoupment.

Fiscal Accountability Review (FAR) – The ~~DIDS~~DIDD Office of Quality Management, ~~Internal Audit~~ Fiscal Accountability Review (FAR) Unit monitors contracts and conducts onsite reviews. A review of the claims billed is compared to supporting documentation and all discrepancies are noted in a report that is submitted to the contract provider for comment. Recoupment for unsupported charges is made after review of the agency's comments. The initial report and final resolution is then submitted to TennCare for additional follow up where appropriate.

State of Tennessee, Department of Audit, Audit Manual, Section A-2 - Audits cover at least one fiscal year, 12 months, unless otherwise approved by the Comptroller. The Bureau of TennCare (State Medicaid Agency) is subject to an annual audit as required by the Single Audit Act. The audit includes a random sample of each program and includes the 1915c HCBS waiver programs. Requests for documentation to support paid claims are made directly to selected providers by the Department of Audit and all information is submitted by providers to this Department. At the completion of the audit process, a comprehensive report is submitted to TennCare staff for review and follow-up to insure that findings are not repeated in subsequent years.

C. Agency (or agencies) responsible for conducting the financial audit program:

- The Bureau of TennCare conducts utilization reviews of the HCBS waivers.

- The Department of Intellectual and Developmental Disabilities (DIDD) Office of Quality Management Financial Accountability Reviews Unit (FAR) conducts the Fiscal Accountability Reviews.

- The Division of State Audit of Tennessee Comptroller of the Treasury, under an agreement with the TennCare Bureau of the Department of Finance and Administration, performs an annual audit of the State's TennCare program.

Appendix I: Financial Accountability
Quality Improvement: Financial Accountability

ii. Performance Measure a.i.3. ("Less than 100% review: Other) ~~DIDS~~DIDD FAR auditors review 100% of providers with paid claims in excess of $300,000 for the previous fiscal year. A sample of 10% of waiver participant records (not to exceed 20 records) is selected for the audit of providers with paid claims exceeding $300,000. For providers with paid claims exceeding $5 million, the sample size increases to 20% (not to exceed 40 records). Auditors are allowed to select their samples, which must include a billing period of at least three months of the billing year.

b. Methods for Remediation/Fixing Individual Problems

i. Performance Measure a.i.1.: The TennCare MMIS system generates a Remittance Advice Report listing the status of all submitted claims, including those approved, those denied, and those suspended. ~~DIDS~~DIDD Administrative Unit staff receive reports following each billing cycle. ~~DIDS~~DIDD must correct errors, based on the reason for denial specified in the report, and resubmit the corrected claims within six months. If the error is not appropriately corrected upon resubmission, the claim will be denied again. Upon second denial of a claim, TennCare will issue a written notice to ~~DIDS~~DIDD indicating that a resubmitted claim was denied and cannot be paid until errors are appropriately corrected. TennCare will provide technical assistance as needed to ensure correction of the error. TennCare will track the number of claims denied multiple times for the same error. If more than two denials are generated for the same claim error, TennCare will send a written notice to ~~DIDS~~DIDD requesting corrective action, which may include procedural changes, staff training, or staff disciplinary actions. ~~DIDS~~DIDD will be required to respond with a written explanation of the corrective actions taken within 30 days of receiving the TennCare request for corrective action. Suspended claims are reviewed by designated TennCare staff for determination of the reasons and appropriateness of suspension. TennCare staff will work toward correction of any issues causing the claim to suspend until they are resolved and result in approval or denial of the claim.

Performance Measure a.i.3.: Findings from ~~DIDS~~DIDD FAR audits are included in an audit report that is sent to the audited provider and copied to the ~~DIDS~~DIDD Quality Assurance Director, the ~~DIDS~~DIDD Assistant Commissioner of Community Services, ~~DIDS~~DIDD Compliance Unit staff, the TennCare Office of Internal Audit staff, and the designated TennCare Long Term Care staff. Repeat findings are identified in the report. Payments made for claims with inadequate or missing information are recouped, unless the provider responds with additional information to justify claims billed. Audited providers will be required to submit a management response to ~~DIDS~~DIDD FAR reports within 30 days. Responses may include additional information to justify billing, agreement with findings and identification of management strategies to improve documentation and billing processes, or a combination of both. For responses not received within 30 days, the ~~DIDS~~DIDD FAR Director will send a notice advising that the response is due and specifying a second due date. If no response is received by the second due date, the provider is advised that ~~DIDS~~DIDD will proceed with the recoupment. The ~~DIDS~~DIDD FAR Director will track recoupments in a database. At the end of each audit period (calendar year), a final reckoning process will be initiated. If recouped amounts have not been collected from the provider, the amount will be withheld from provider payments so that all recoupments for the audit cycle are collected no later than the end of the first quarter of the subsequent calendar year (March 31). ~~DIDS~~DIDD FAR auditors collect information identifying the waiver program in which the waiver participant whose records are being reviewed is enrolled. Consequently, audit data is available by waiver program. ~~DIDS~~DIDD reports monthly data to TennCare including the number of FAR audits completed, the number of providers for whom findings were identified, the amount of recoupments identified, and the number of findings for each provider. Designated ~~DIDS~~DIDD Compliance Unit Staff will receive an annual summary from the ~~DIDS~~DIDD FAR Director regarding collection of recoupments from providers resulting from ~~DIDS~~DIDD FAR findings.

Individual Remediation Data Aggregation: ~~DIDS~~DIDD has developed a data flow document which identifies data collection, reporting, and aggregation tasks that must be completed to generate the required reports for submission to TennCare. For each task, due dates are specified. Responsible ~~DIDS~~DIDD staff and back-up staff are identified for each task.

Designated ~~DIDS~~DIDD Central Office staff compile the data collected and entered by regional and central office staff into ~~DIDS~~DIDD databases to create data files that are posted for TennCare analysis and aggregation. In addition, ~~DIDS~~DIDD generates a Quality Management Report using the data collected and reported. The Quality Management Report is submitted to TennCare each month and information contained therein is reviewed during monthly State Quality Management Committee Meetings. ~~TennCare compiles monthly Compliance Summary Reports from DIDSDIDD data, which are also reviewed and analyzed during State Quality Management Meetings. Reports include information regarding the number of sample reviews completed, compliance percentages, individual remediation activities and timeframes required for remediation. Reports include cumulative totals for the waiver year to date. TennCare Compliance Summary Reports are distributed to DIDSDIDD management staff for discussion and analysis during monthly State Quality Management Committee Meetings.~~

Appendix I: Financial Accountability
I-2: Rates, Billing and Claims

a. Rate Determination Methods.

Service rates are determined by the ~~Division of Intellectual Disabilities Services (DIDS~~) Department of Intellectual and Developmental Disabilities (DIDD) and are approved by TennCare, the Medicaid Agency. Maximum allowable rates are established for each service based on an analysis of provider costs to deliver services and based on experience. Rates must be sufficient to recruit an adequate supply of qualified providers for each service to ensure participants statewide have adequate access to waiver services. In setting rates, rates for similar services in other state programs are considered. The amount of state funds appropriated to ~~DIDS~~DIDD must be sufficient to support the state share of all rates within the program. Providers are reimbursed up to the maximum allowable rate established for a service. Stakeholders have the opportunity to provide input into the sufficiency of rates through the ~~DIDS~~DIDD ~~Advisory Council~~ Statewide Planning and Policy Council, provider meetings, and other public meetings, as well as through the ~~DIDS~~DIDD rule-making hearing process.

Persons who choose to self-direct have input into setting rates for workers. For each service, a maximum allowable rate is set by ~~DIDS~~DIDD and approved by TennCare. Those self-directing may determine rates for workers that are no greater than the maximum allowable rate.

b. Flow of Billings

~~Providers are given a choice of submitting claims for reimbursement to either TennCare or DIDS DIDD . All providers currently have chosen to submit their claims for reimbursement to DIDS DIDD. Each provider has signed a statement making this choice and voluntarily reassigning their right of direct payment to DIDS DIDD.~~

All Waiver services are prior approved by ~~DIDS~~DIDD. Providers submit invoices for delivered services to the ~~DIDS~~ DIDD central office. The ~~DIDS~~DIDD system has numerous edits including an edit that verifies the services provided on the date of service were approved in the participant's plan of care.

The ~~DIDS~~DIDD system converts the provider claims that successfully process through all of its edits to the appropriate claim format and submits the claims electronically to TennCare for processing through the MMIS. The MMIS processes the claims, and returns the remittance advices electronically ~~to each provider and DIDS~~ to DIDD and a hard copy to each provider~~.~~

~~along with payment for all claims that paid.~~ ~~. DIDS~~ ~~DIDD~~ TennCare issues reimbursement payments to the providers. Providers retain 100% of the payment calculated in the MMIS.

For waiver services that are self-directed, the invoice for waiver services is signed off on by the participant and is submitted to a financial management services company. The financial management services company processes payroll to the workers then submits a claim for the waiver services to ~~DIDS~~ DIDD, as do all other providers. The claims process through ~~DIDS~~ DIDD edits and are electronically sent to TennCare for processing through the MMIS. ~~The financial management services company has a provider agreement with DIDS DIDD and TennCare and has voluntarily reassigned payment to DIDS DIDD . DIDS DIDD reimburses the service provider for waiver services that successfully process through the MMIS.~~ The financial management services contractor receives payment and a remittance advice directly from TennCare and pays workers who are employed by participants from the funds.

The financial management services company provides payroll and support broker services under an administrative contract. For administrative services, the financial management services company submits a monthly invoice to ~~DIDS~~ DIDD based on the number of participants served that month, separately indicating the number of participants who received supports brokerage services and the number of participants who received financial management services. The contractor is reimbursed through administrative claiming for these service components.

d. Billing Validation Process.

~~DIDS~~DIDD approves services in the plan of care. By choice, all providers submit service invoices to ~~DIDS~~DIDD . The ~~DIDS~~DIDD system validates service invoices against the ~~DIDS~~ DIDD approved service plans. The ~~DIDS~~DIDD system creates a claim for services that were in an approved plan and submits the claims to TennCare for processing through the MMIS. When the claims process through the MMIS, the system checks to verify that the person had an active Pre-Admission Evaluation establishing waiver eligibility, and the person's eligibility for Medicaid on the date of service is verified. Claims are processed against a number of other edits or audits within the MMIS. Post-payment reviews are conducted by the ~~DIDS~~DIDD Internal Audit Unit and by TennCare to ensure services were provided.

Appendix I: Financial Accountability

I-3: Payment

g. Additional payment arrangements:

i. Voluntary reassignment of payments –

~~The Division of Intellectual Disabilities Services.~~ ~~Department of Intellectual and Developmental Disabilities (DIDD)~~

ii. Organized Health Care Delivery System.

1. **Change to yes,** and specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

(a) The Department of Intellectual and Developmental Disabilities (hereinafter "Department" or "DIDD") is a public government organization which delivers health care services to people with intellectual and developmental disabilities who are enrolled in the State's Medicaid waiver. Department employees deliver health care services at the DIDD Regional Resources Centers located in West, Middle, and East Tennessee. The health care services delivered by DIDD employees include behavior services, dental services, nutrition services, occupational therapy, physical therapy, specialized medical equipment, supplies, and assistive technology, and speech language and hearing services. The Department contracts with other qualified providers to furnish other waiver services. All Department employees delivering said health care services, as well as other qualified providers, are required to satisfy waiver requirements regarding qualifications and service standards.

(b) The Department does not require waiver providers to affiliate with the Regional Resource Centers. Waiver providers who elect not to affiliate with the Regional Resource Centers are able to enter into a three-way agreement with the Department and the single State Medicaid Agency (TennCare) through the usual and customary process for direct provider enrollment. A waiver provider's decision on whether or not to agree to contract with the Regional Resource Centers does not have any bearing on the provider's enrollment as a waiver provider.

(c) Waiver participants are not required to secure services through the Regional Resource Centers. When an individual is determined to be likely to require the level of care provided by an ICF/IDD, DIDD informs the individual or the individual′s legal representative of any feasible alternatives available under the waiver program, including a description of the waiver services and names and addresses of all available qualified providers, and offers the choice of either institutional or waiver services.

In addition, individuals are given a Freedom of Choice form which contains a simple explanation of the waiver and waiver services; a statement that participation in the Waiver is voluntary; and notification of the opportunity to apply for enrollment in the Waiver and an explanation of the procedures for enrollment. The Freedom of Choice form is explained and the signature of the person to receive waiver services or the legal representative will be obtained on the Freedom of Choice form, which is completed prior to admission into the waiver program.

(d) Any staff person who has direct contact with or direct responsibility for a waiver participant must pass a criminal background check performed in accordance with a process approved by the Department of Intellectual and Developmental Disabilities and must not be listed on the Tennessee Department of Health Abuse Registry, the Tennessee Sexual Offender Registry, the Tennessee Felony Offender List, or the Office of Inspector General Exclusion List.

A statewide criminal background check is performed by the Tennessee Bureau of Investigation or a Tennessee-licensed private investigation company. If the staff person has resided in Tennessee for one year or less, a nationwide criminal background check is required in accordance with DIDD requirements.

The Bureau of TennCare shall conduct Qualified Provider Reviews of DIDD personnel files to ensure that there is documentation that the mandatory background and registry checks have been conducted on potential staff that will have direct contact with or direct responsibility for waiver participants.

(e) TennCare reviews and approves the final language contained in the three-way provider agreement template which specifies provider requirements and responsibilities as well as DIDD and TennCare responsibilities in administration/operation of the waiver program. TennCare reviews individual waiver provider and administrative contracts prior to execution and is a signatory on all such contracts. This process assures that OHCDS contracts meet applicable requirements.

(f) Financial accountability is assured through the audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services**.**

Utilization Review Process - The Bureau of TennCare conducts utilization reviews of the HCBS waivers for persons with intellectual disabilities to determine compliance with federal and state regulations and waiver requirements. Post-payment claim reviews to ensure that services are appropriately documented and appropriately billed are conducted as part of the utilization review process. Utilization reviews are conducted according to a predetermined audit schedule for the year. Reviews are conducted in each region of the state, and cover different waiver services each month. The person sample is identified by entering the following data into the TennCare Interchange System: 1.) waiver provider number; 2.) dates of service; 3.) procedure code for the review; and 4.) paid status. The process includes a review of the approved service plan with the amount, frequency and duration, review of the billing documents and supporting documentation, and a comparison of all documents to adjudicated claims. Identified inconsistencies are documented and researched. Unsupported and/or inappropriate payments result in recoupment.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds

State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.

Funding is appropriated to the ~~Division of Intellectual Disabilities Services (DIDS)~~ Department of Intellectual and Developmental Disabilities (DIDD). ~~DIDS is a division within the Department of Finance and Administration.~~